SUPREME COURT, U. S.

Supreme Court, U. S.
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in the

Supreme Court

of the

United States

OCTOBER TERM, 1975

No. 75-3861

KENNETH B. FORMAN,

Petitioner,

vs.

MASSACHUSETTS CASUALTY INSURANCE COMPANY,
a Massachusetts Corporation,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

The petitioner Kenneth B. Forman respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Fifth Circuit entered in this proceeding on July 25, 1975.

OPINION BELOW

The opinion of the Court of Appeals, not yet reported, appears in the Appendix hereto at App. 1. The Final Judgment of the District Court for the Southern District of Florida and Amendment to Final Judgment appear in the Appendix at App. 9.

JURISDICTION

The Judgment of the Court of Appeals for the Fifth Circuit was entered on July 25, 1975. A timely petition for rehearing and petition for rehearing *en banc* was denied on November 14, 1975, and this petition for certiorari was filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

QUESTION PRESENTED

The United States Court of Appeals for the Fifth Circuit has reversed a final judgment in favor of an insured claiming benefits under a sickness and accident policy containing "incontestable" provisions required by Florida Statute §627.607 imposing a time limit on certain defenses to claims made under a policy. The question presented is:

Whether the Fifth Circuit has construed Florida Statute §627.607 so as to reach a result directly opposite to and conflicting with clear and controlling rulings by the Supreme Court of Florida on an aspect of State insurance law having major importance?

STATUTORY PROVISIONS INVOLVED

Florida Statute §627.607:

Time limit on certain defenses. —
There shall be a provision as follows:

"Time Limit on Certain Defenses: (1) After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such three-year period."

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial three-year period, nor to limit the application of §§627.619-627.623 in the event of misstatement with respect to age or occupation or other insurance.)

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (a) Until at least age fifty or, (b) In the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "Incontestable":

"After this policy has been in force for a period of three years during the lifetime of the insured (excluding

any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

"(2) No claim for loss incurred or disability (as defined in the policy) commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(For the purpose of permitting insurers to use a uniform policy in several states, the insurer is permitted to print in the policy form in required provisions (1) and (2), above, the term "three years." Nevertheless, the provisions of the contract and test of the statute to the contrary notwithstanding, the time limits for such defenses under any contract delivered or issued for delivery to any person in this state shall not exceed two years.)

STATEMENT OF THE CASE

The jurisdiction of the District Court was invoked because of diversity of citizenship, the plaintiff being a Massachusetts corporation and the defendant a citizen of Florida. Suit was brought by the plaintiff insurance company on November 16, 1971, seeking rescission and cancellation of an accident and health insurance policy issued by the plaintiff to defendant. (R.1-20).

The policy in issue resulted from defendant Forman's action in the latter part of 1969, seeking health and accident disability insurance from one Allen Davis, an insurance agent in New York, who wrote policies for various insurance companies, including Massachusetts Casualty Insurance Company. (Tr. 473, 513). In response thereto, Davis mailed Forman a blank Massachusetts Casualty application form (R. 19) with instructions to sign where he, Davis, indicated and to return it to him in New York. (Tr. 98-100, 201-202, 236, 249, 250, 270, 275, 281, 283, 509, 511-512). Thereafter, Davis himself, without Forman supplying answers, completed the application (Tr. 263, 236, 249-250, 270, 275, 281, 283, 509) dated October 13, 1969, and filed it with the insurance company. (Tr. 513).

The company received the application as completed by agent Davis but did not rely upon the answers to the questions contained therein before it accepted the application. (Tr. 54, 55). Instead, the company employed an independent investigating agency, Retail Credit Company, for the purpose of making its own independent inquiry into health, earnings and other general background questions concerning Forman. (Tr. 34). Based upon the "Health Report" from the Retail Credit Company, the company issued the subject policy to Forman effective November 20, 1969. (R. 7).

The evidence supports (Tr. 38, 54) and the trial judge specifically found in his Findings of Fact (R. 583) that the company would not have issued the policy of insurance to Forman without obtaining its own independent "Health Report."

From February 19, 1970, to April 14, 1970, (Tr. 312) and in subsequent periods from September 13, 1970, to September 26, 1970, and from February 22, 1971, to March 1, 1971, (Tr. 358) Forman was admitted to Broward General Medical Center with what the attending physician, Dr. Glass, diagnosed as juvenile brittle diabetes mellitus (Tr. 328), which is an uncontrollable type of diabetes. (Tr. 359). Dr. Roy Glass unequivocally found Forman totally disabled from juvenile brittle diabetes mellitus as of February 19, 1970. (Tr. 334).

On April 14, 1970, Forman filed the preliminary claim notice with the company and on June 24, 1971, he executed a proof of loss and filed a claim for payment alleging total disability as a result of diabetes. (Tr. 29).

The company paid Forman a total of $5,500.00 as indemnity under the policy until it determined to rescind and cancel the policy for alleged misrepresentation of Forman's monthly earned income in the application for insurance. Forman was advised of this decision by letter of November 1, 1971. (R. 5).

The policy issued to Forman, in conformity with Florida law, contained the following incontestable clause:

> INCONTESTABLE: A. After this Policy has been in force for a period of two years, during the lifetime of the Insured, it shall become incontestable as to the statements contained in the copy of the application. B. No claim (as defined in the Policy) commencing after two years from the date of issue of this Policy shall

> be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

On November 16, 1971, four days before the contestable period under Forman's policy was to have expired, the company filed its Complaint against Forman seeking rescission and cancellation of the policy. (R. 1-20). The Complaint solely alleged misrepresentation of monthly earned income in the insurance application.

Forman filed an Answer and Counterclaim on December 6, 1971, denying the falsity of any representations concerning monthly earned income and denying that he made any false and fraudulent representations to the company. (R. 24-29). In addition, Forman sought enforcement of the policy, alleging that he had been totally disabled since February 19, 1970. (R. 28).

On May 19, 1972, almost six months after the expiration of the contestable period, the company moved for Leave to Amend its Complaint (R. 147-149), alleging as grounds therefore new and additional bases for rescission and cancellation of the policy. Specifically, those were that Forman in his application had falsely represented that he had never suffered from diabetes and that he had never been medically treated during a period of ten years prior to the dates on the application.

Forman was, in fact, a patient at Brookdale Hospital Medical Center in New York during two periods: he had

been hospitalized from September 7, 1968, to September 20, 1968, with a diagnosis of acute cholecystitis with pancreatitis, and from November 14, 1968, to December 2, 1968, with a diagnosis of diabetes mellitus, status postpancreatitis. (R. 186-188). This information had been voluntarily supplied to the company on March 21, 1972, in Forman's testimony correcting his February 14, 1972, deposition. (R. 87-89). Nevertheless, Forman asserted at the same time that he had not supplied answers to the questions on the insurance application. (Tr. 233-236, R. 87-89).

The company's Motion for Leave to Amend was granted over objection. (R. 51). Thereafter, Forman filed a Motion to Vacate (R. 452-453) directed at the Order Granting Leave to Amend and simultaneously filed a Motion to Dismiss or Strike the Amendment on the ground that the matters alleged in the Amendment were barred by the incontestable clause of the policy, which clause had expired on November 20, 1971. (R. 457-458). Both motions were denied, and Forman then filed his Answer to the Amended Complaint again asserting the incontestable clause as an affirmative defense. (R. 492-497). While the Court ruled that the Company's Amended Complaint of May 19, 1972, should relate back to the filing of the original Complaint on November 16, 1971, pursuant to Rule 15(c) of the Federal Rules of Civil Procedure (R. 558), the court clarified that Order at the outset of trial by ruling that Forman could assert the incontestable clause as an affirmative defense to the allegation of misrepresentation of previous health history of the Amended Complaint. (Tr. 15).

On November 20, 1973, the trial court entered a Final Judgment for the insured, Kenneth B. Forman. (R. 582-

586). From that Final Judgment as amended (R. 600-601), the Massachusetts Casualty Insurance Company appealed and obtained a reversal in part by the United States Court of Appeals for the Fifth Circuit on July 25, 1975. The District Court Judgment in favor of Forman amounting to $30,800.00 for accrued benefits in addition to an anticipated $400,000.00 in total benefits if Forman lived to life expectancy, plus attorney's fees of $65,000.00 was reversed by the Court of Appeals on the sole ground that the incontestability provisions of Forman's policy did not and could not cause a prior-existing illness to become covered by the policy. (Slip decision at 6735, App. at 15-16).

Forman petitioned for rehearing and for rehearing en banc on the basis that the Court of Appeals had misapprehended Florida case law controlling the effect of the subject incontestable clause, and had reached a result contrary to that required by the case law of the forum state. On November 14, 1975, the United States Court of Appeals for the Fifth Circuit denied Forman's Petition for Rehearing and Petition for Rehearing En Banc. (App. at 25).

REASONS FOR GRANTING THE WRIT

I.

THE DECISION BELOW, IN VIOLATION OF THIS COURT'S MANDATE IN *ERIE R. CO. v. TOMPKINS*, 304 U.S. 64 (1938), CONFLICTS WITH THE DECISION OF THE HIGHEST COURT OF THE STATE OF FLORIDA AS TO THE PROPER INTERPRE-

TATION OF FLORIDA STATUTE §627.607, A STATE INSURANCE REQUIREMENT OF MAJOR IMPORTANCE, HAVING COUNTERPART PROVISIONS IN THE STATUTORY LAW OF THE MAJORITY OF THE STATES.

II.

THE DECISION BELOW, IF ALLOWED TO STAND, WILL BE AN IMPLICIT INVITATION TO THE EVER EXPANDING HEALTH INSURANCE INDUSTRY (THERE ARE OVER 182 MILLION AMERICANS PROTECTED BY HEALTH INSURANCE) TO CONTEST PAYMENT OF BENEFITS ON THE BASIS OF FEDERAL CRITERIA NOT PREVIOUSLY APPLICABLE IN DIVERSITY CASES.

The controlling issue inherent in the instant case from its inception has been one of application of state substantive law to a suit brought in a federal court in the forum state. Inasmuch as the Court of Appeals has reversed the lower court's decision in favor of the insured based upon its reading of state statutory insurance law, a direct conflict has been created between the decision of the United States Court of Appeals for the Fifth Circuit and the highest court of the State of Florida. Although the subject of the decision is a nonfederal matter, the refusal of the United States Court of Appeals to follow the rulings of and thus to conflict with the Supreme Court

of Florida is ground for review by this Court of the decision of the Court of Appeals. Such a ruling arising out of federal court jurisdiction grounded upon diversity of citizenship is inconsistent with this Court's original mandate in *Erie R. Co. v. Tompkins*, 304 U.S. 64 (1938). Violation of this mandate in cases raising matters of state law involving questions of exceptional importance is a significant basis for review by this Court. See *Russell v. Todd*, 309 U.S. 280 (1940); *Wichita Royalty Co. v. City Nat. Bank*, 306 U.S. 103 (1939); *Guaranty Trust Co. v. York*, 326 U.S. 99 (1945).

Florida by statute requires that certain aspects of the contract for insurance coverage be incontestable after the policy has been in effect for a period of two years during the insured's lifetime. Fla. Stat. §627.607. That statute requires as a further provision that no claim for a disability commencing after two years from the date of issue of the policy shall be denied on the ground that it had existed prior to the effective date of coverage of the policy. This provision is of such major significance that it is required by the insurance codes of the majority of the states.[1]

Moreover, the decision herein sought to be reviewed has importance that reaches beyond the decision's immediate consequence for the actual litigants. The subject incontestable clause imposing a time limit on certain de-

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[1]Ariz. Rev. Stat. §20-1346; Ark. Stat. §66-3605; Alaska Stat. §21.51.050; Cal. Ins. Code §10350.2; Dist. of Columbia Code §35-7123; Conn. Gen. Stat. §38-167; Del. Code §3306; Idaho Code §41-2106; Ill. Stat. §969 a; Ind. Stat. §27-8-5-3(2); Kan. Stat. §40-2203; La. Rev. Stat. §22:213(13); Me. Rev. Stat. Title 24 A §2706; Md. Code Art.

fenses available to an insurer is not unique to Florida but has virtually national scope. See footnote 1, *supra*. Nevertheless, those states which have considered the present issue have not reached uniform positions but are in disagreement and therefore resist the superimposition of a single body of federal law. See Construction of Incontestable Clause Applicable To Disability Insurance, 13 A.L.R.3d 1383.

Despite the paucity of decisional law on point in the multitude of jurisdictions requiring comparable incontestable clauses, rapid growth in the extent of coverage of the American population under accident and health insurance must be deemed a forewarning of increased litigation in this area. The most recent surveys currently available, although compiled only through the year 1973, indicate that 182 million Americans, or nearly 9 out of 10 of the civilian resident population, are protected by health insurance[2]. Over the immediately preceding five-year period, the benefits paid under long-term disability provisions of such policies reflected a percentage increase in excess of 98 percent.[3] Meanwhile, the cost of this coverage in the form of premiums of those insured has reached $28.8 billion.[4]

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48 A §441; Mass. Gen. Laws 175-§108(2); Mich. Comp. Laws 500:3408; Minn. Stat. §62 A.04(2); Miss. Code §83-9-5(1)(b); Missouri Stat. §376.777(2); Neb. Rev. Stat. §44-710.03(2); N.H. Rev. Stat. §415:6(A)(2); N.J. Stat. 17:38-13.2(A)(2); N. Mex. Stat. 58-11-4(A)(2); N.Y. Ins. Law Art. 7 §163(3)(2); No. Car. Gen. Stat. §58-251(2); N. Dak. Cent. Code 26-03A-03(b); Okla. Stat. 36 §4405(2); Penn. Stat. 40 §753(A)(2); R.I. Gen. Laws 27-18-3(2); So. Car. Code CL. 6 §37-473(2); Tenn. Code 56-3308(2); Vt. Stat. Title 8 §4065(2); Va. Code §38.1-349(2); Wash. Rev. Code 48.20.052.

[2]The Health Insurance Institute, *Source Book of Health Insurance Data 1974-1975*, Sixteenth Edition, at 19.

[3]*Id.* at 5.

[4]*Id.* at 45.

The decision of the Court of Appeals below, in derogation of Florida law, is an implicit invitation to the insurance industry to contest the payment of benefits to existing policyholders on a basis not previously available under the law deemed applicable at the time such policies were issued. Since comparable incontestable clauses are required by the clear majority of the states, the decision of the Fifth Circuit will serve as a broadened basis for litigation on health and accident policies on a national basis as well.

The decision of the Court of Appeals directly reviewed the scope of the foregoing Florida statute and held that it could not serve to bring Forman's diabetes within the policy because the "sickness" for which Forman claimed benefits had " 'first manifested' itself before the policy was issued." Opinion at 6734, App. at 15. This holding directly conflicts with clear and controlling Florida case law which holds that a "sickness" first manifests itself not when it first becomes known to the insured but rather when the condition affects the insured's capacity to perform his occupation, the occurrence of which in the instant case was after the policy became effective.

In *Continental Casualty Co. v. Gold*, 194 So.2d 272 (Fla. 1967) the Supreme Court of Florida had before it an issue identical to the issue which was dispositive of this case, namely whether the issurance company could disallow coverage of an illness because evidence of the existence of the disease for which benefits were claimed predated the policy and the terms of the policy covered only sickness or disease "contracted and commencing after this policy has been in force . . . " *Id.* at 275. In *Continental Casualty Co. v. Gold*, there was much evidence of the in-

sured's hospitalization and medical consultation prior to the effective date of his policy with symptoms of sickness which reappeared after the policy became effective and resulted in a new hospitalization. The new hospitalization was the basis for the claim under the policy. Therefore, as the Supreme Court of Florida phrased the issue, the jury was presented with conflicting evidence as to when the sickness causing the new hospitalization "first became manifest." *Id.* at 275.

In upholding the trial judge's instruction to the jury that the word 'sickness' is a " . . . diseased condition [that] has advanced far enough to incapacitate. . . " the Florida Supreme Court stated that, as a general rule, a person is not considered "sick" — even though one organ of his body may be affected — until the disease has advanced far enough to incapacitate him to perform his usual work. The Florida high court also stated that the above test of incapacitation will be applied to determine whether the insured person's sickness originated or "manifested itself" before the effective date of the policy. *See generally* 18 Fla. Jur. "Insurance," §683 page 663. Concluding that the insurance company presented no evidence that the insured was *incapacitated* before the policy became effective, the Court held for the insured.

There can be no legitimate question but that *Gold* is the controlling law in the State of Florida. Recently, the Supreme Court of Florida's opinion in *Continental Casualty Co. v. Gold,* was cited approvingly in another case factually very similar to the instant case, that of *Continental Casualty Co. v. Fooden,* 293 So.2d 758 (Fla. 3d Dist. 1974). In *Fooden* the insured's heart problem (a

condition for which benefits were claimed) first "manifested" itself in 1965. In November of 1969, *one month prior* to the effective date of the insurance policy, the insured consulted a doctor who tentatively diagnosed a right carotid insufficiency and ordered an arteriogram. The evidence in the *Fooden* case showed that in March of 1971, the insured became "disabled". The court held that the company could not deny coverage on the basis that the insured's illness was a pre-existing condition. Relying upon *Continental Casualty Company v. Gold, supra,* the court found dispositive the Florida Supreme Court's definition of "sickness" as a "diseased condition which has advanced far enough to incapacitate an individual from performing his usual activities." 293 So.2d at 759.

Thus, although Florida law draws no effective distinction between "manifestation" and "existence", the Court of Appeals declined to grant the law of the forum controlling effect, but instead avoided it by applying the "great weight of authority, including decisions of this court" holding that an incontestable clause does not negate an insurer's defense that the particular disability was never within the policy's coverage. (Opinion at 6735, App. at 16).

Granting the effect of Florida law would have compelled a decision contrary to that reached by the Fifth Circuit since subparagraph B of the statutory incontestable clause, giving its words their plain and common meaning, prohibits a denial of claim based on the prior existence of a disease. The decision below held that subparagraph B had no "effective field of operation," even

in a Florida case, because the law applied by the court was not that of the forum but the general law of the circuit.

The decision below is an erroneous application of the law of the forum for a second and separate reason. It is the prevailing rule in Florida that as a matter of construction incontestable clauses in insurance policies are favored in the law and are to be construed in favor of the insured and against the insurer. *Continental Casualty Company v. Fooden, supra.* This rule applies to both ambiguous or uncertain provisions as well as time limitation clauses. The Court in *Fooden* viewed the controlling state law as follows:

> In our view this case falls within the rule enunciated in Continental Casualty Company v. Gold, Fla. 1967, 194 So.2d 272 that in determining what losses are covered by an insurance policy insuring against loss due to sickness or disease, ambiguous or uncertain provisions will be construed in favor of the insured.
>
> Similarly, provisions in such policies which require that a sickness or disease originate at some specified time after the policy takes effect in order to provide coverage are strictly construed against the insurer. See, Annot. 53 ALR2d 686, 589; Boyle v. Springfield Life Ins. Co., Cir. Ct. 1972, 38 Fla. Supp. 84, aff'd Springfield Life Ins. Co. v. Boyle, Fla. App. 1973, 272 So.2d 826.
>
> Id. at 759.

Had the case at bar been filed in state court, Florida substantive law would be controlling and would compel a decision in favor of Forman's coverage under the policy. The contrary result obtained upon the erroneous application of general federal insurance law by the Court of Appeals. There is little reason not to give Florida law its full and proper effect. To hold otherwise, as did the Court of Appeals below, is to create a classic basis for forum shopping, ostensibly improper since this Court's landmark decision in *Erie R. Co. v. Tompkins, supra.*

Furthermore, since the most attractive forum for an insurance company under the precedent established below will be the Federal District Court, the consequence of that decision will be an encouragement to the litigating insurance company to file in Federal Court rather than State Court. The reasonable anticipation of a significant increase in cases added to already congested federal trial dockets makes the necessity of review of the Fifth Circuit's ruling all the more compelling.

The correctness of the decision below is open to serious question as a matter of Florida law. The refusal of the Court of Appeals to respect state law governing an aspect of insurance legislation in widespread use among the states cannot be justified. The decision below now stands as precedent clouding the substantial rights of numerous persons insured under similar policies, and as such should not be left unreviewed.

CONCLUSION

For these reasons, a writ of certiorari should issue to review the judgment and opinion of the United States Court of Appeals for the Fifth Circuit.

Respectfully submitted,

/s/ Burton Young
BURTON YOUNG

/s/ William L. Rogers
WILLIAM L. ROGERS

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IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1975

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Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

AFFIDAVIT OF SERVICE

STATE OF FLORIDA)
) SS
COUNTY OF DADE)

I, WILLIAM L. ROGERS, first being duly sworn according to law, do depose and say:

I HEREBY CERTIFY that three (3) copies of the foregoing Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit was served

upon Lucius Cushman of Cushman & Cushman, 444 Brickell Avenue, Suite 428, Miami, Florida 33131, Attorney for Respondent, by mailing copies of same to him by United States Mail, First Class postage prepaid, pursuant to Rule 33 of this Court, this day of December, 1975.

/s/ William L. Rogers
WILLIAM L. ROGERS

SWORN TO and SUBSCRIBED BEFORE ME at Miami, Dade County, Florida, this day of December, 1975.

NOTARY PUBLIC
State of Florida

My Commission Expires:

APPENDIX

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

NO. 71-1757-Civ-WM

MASSACHUSETTS CASUALTY
INSURANCE COMPANY, a
Massachusetts corporation,

Plaintiff,

vs.

KENNETH A. FORMAN

Defendant.

Filed November 20, 1973

FINDINGS OF FACT, CONCLUSION OF LAW, AND FINAL JUDGMENT

This cause came on for trial and the Court having considered the unilateral pretrial stipulations, all of the evidence tendered by the parties and received by the Court, finds the facts, states the conclusions of law, and enters judgment as follows:

FINDINGS OF FACT

1. That on the 20th day of November, 1969, the plaintiff, counter-defendant, Massachusetts Casualty Insurance Company, issued to the defendant, counter-

plaintiff, Kenneth B. Forman, its accident and health disability insurance policy #12285.

2. That the application for said policy, which is appended to the policy, was transmitted to the defendant insured from New York to Florida through the mail by Alan D. Davis, an independent insurance agent who writes policies for various insurance companies including Massachusetts Casualty Insurance Company, and who is paid commissions therefor by the said insurance companies. That the defendant, counter-plaintiff signed the said application in blank, as directed, and mailed the same back to Alan D. Davis in New York who completed same, signed the same as "agent" as the application form required, and filed the same for processing with Massachusetts Casualty Insurance Company.

3. That the plaintiff, counter-defendant received the said application, but did not rely solely upon the answers to the questions contained therein before it issued the said policy to the defendant, counter-plaintiff. Instead, the plaintiff, counter-defendant employed an independent investigating agency, viz: Retail Credit Company, with offices in Fort Lauderdale, Florida, for the purpose of making its own inquiry into the health, earning and other background questions it had of the applicant, the defendant, counter-plaintiff, Kenneth B. Forman.

4. That the plaintiff, counter-defendant received a "Health Report" from Retail Credit Company, its independent investigating company. The Court finds that the plaintiff, counter-defendant reviewed the said "Health Report" and thereafter issued the said policy of insurance

to the defendant, counter-plaintiff, Kenneth B. Forman. The Court finds that the plaintiff, counter-defendant would not have issued said policy of insurance without obtaining its own "Health Report" from its own independent investigating company. The cost of said report to the plaintiff, counter-defendant was estimated to be approximately $9.00. That the defendant, counter-plaintiff's wife was never contacted and interrogated by Retail Credit Company or anyone else prior to the issuance of the said policy of insurance.

5. That defendant, counter-plaintiff made claim for total disability payments under the said policy of insurance on June 24, 1971, and completed all the required forms therefor.

6. That the plaintiff, counter-defendant paid the defendant, counter-plaintiff the sum of Five Thousand Five Hundred ($5,500.00) Dollars for total disability payments, but ceased all payments on November 1, 1971.

7. That by letter of November 1, 1971, the plaintiff, counter-defendant attempted to rescind and cancel the subject policy upon the sole ground that the defendant, counter-plaintiff misrepresented his actual earned income at the time he "... applied for the Policy ..."

8. That the plaintiff, counter-defendant filed its complaint in this Court on November 16, 1971, seeking to rescind and cancel the subject policy on the sole ground as delineated in its letter to the defendant, counter- plaintiff of November 1, 1971. That the Court finds that there

was no misrepresentation with regard to the defendant, counter-plaintiff's earned income.

9. On April 10, 1973, the Court allowed the plaintiff, counter-defendant to amend its complaint and plaintiff, counter-defendant did so, injecting a new and different additional consideration as grounds to rescind and cancel the said policy. The defendant, counter-plaintiff met the new and additional considerations in a responsive pleading contending that the "incontestable clause" in said insurance policy precluded the plaintiff, counter-defendant from invoking new and additional grounds for cancellation.

10. The "incontestable clause" contained in said policy of insurance became effectual on November 20, 1971.

11. That the defendant, counter-plaintiff, Kenneth B. Forman, is totally disabled within the meaning of the policy as a result of sickness as defined therein.

12. That the defendant, counter-plaintiff is thirty-five years of age.

CONCLUSIONS OF LAW

13. That the Court has jurisdiction of the parties and the subject matter of this cause.

14. That the plaintiff, counter-defendant failed to prove by a preponderance of the evidence any valid ground

to rescind and cancel the subject policy of insurance, and therefore, its complaint and its amendment should be dismissed.

15. That the defendant, counter-plaintiff, Kenneth B. Forman, by a preponderance of the evidence, has proven his affirmative defenses and the material allegations of his counterclaim which, in effect, seeks to compel the plaintiff, counter-defendant to perform under the said policy of insurance. The said defendant, counter-plaintiff further seeks attorneys' fees and costs, to which an entitlement has been shown.

16. That the equities are with the defendant, counter-plaintiff, and against the plaintiff, counter-defendant.

FINAL JUDGMENT

17. That the plaintiff's complaint, as amended, be, and the same is hereby, dismissed, and the plaintiff, Massachusetts Casualty Insurance Company, takes nothing and is taxed with all court costs and the counter-plaintiff's attorneys' fees which will be assessed following an evidentiary hearing thereon.

18. That judgment is entered in favor of the defendant, counter-plaintiff, Kenneth B. Forman, and against the plaintiff, counter-defendant, Massachusetts Casualty Insurance Company, on the counterclaim. That the plaintiff, counter-defendant shall pay forthwith to the defendant, counter-plaintiff, Kenneth B. Forman, Twenty-Five Thousand ($25,000.00) Dollars, plus accrued interest at the legal

rate, which sum represents all past due total disability payments due under the said policy of insurance from November 1, 1971, to December 1, 1973. Further, the plaintiff, counter-defendant shall continue to comply with all of its undertakings as contained in the policy of insurance, which is the subject matter of this suit, which the Court herein orders specifically enforced.

19. The Court retains jurisdiction to enter such further orders herein as appropriate to enforce this Final Judgment.

ORDERED this 19th day of November, 1973, at Miami, Florida, by

W. O. MEHRTENS
United States District Judge

Copies Furnished Counsel:
Cushman and Cushman
Snyder, Young, Stern & Tannenbaum, P.A.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

NO. 71-1757-Civ-WM

MASSACHUSETTS CASUALTY INSURANCE COMPANY,
a Massachusetts corporation,

Plaintiff,

vs.

KENNETH B. FORMAN,

Defendant.

Filed Dec 10 1973

AMENDMENT TO FINAL JUDGMENT

The defendant, counter-plaintiff, having moved to amend paragraph 18 of the Final Judgment entered in this cause on November 19, 1973 and it having been made to appear to the Court that said motion should be granted, it is accordingly

ORDERED:

1. That paragraph 6 of the Findings of Fact as contained in the Order of November 19, 1973, be amended to read as follows:

> 6. That the plaintiff, counter-defendant, paid the defendant, counter-plaintiff, the sum of Five Thousand Five Hundred ($5,500.00) Dollars for

total disability payments, but ceased all payments on July 18, 1971.

2. That paragraph 18 of the said Order of November 19, 1973 be, and the same hereby is, vacated and that substituted in its stead is the following Order of this Court:

> 18. That judgment is entered in favor of the defendant, counter-plaintiff, Kenneth B. Forman, and against the plaintiff, counter-defendant, Massachusetts Casualty Insurance Company, on the counterclaim. That the plaintiff, counter-defendant, shall pay forthwith to the defendant, counter-plaintiff, Kenneth B. Forman, Thirty Thousand Eight Hundred ($30,800.00) Dollars, plus accrued interest at the legal rate, which sum represents all past due total disability payments due under the said policy of insurance from July 18, 1971, to November 17, 1973. Further, the plaintiff, counter-defendant, shall continue to comply with all of its undertakings as contained in the policy of insurance, which is the subject matter of this suit, which the Court herein orders specifically enforced.

DONE this 10th day of December, 1973, at Miami, Florida, by

/s/ William O. Mehrtens
UNITED STATES DISTRICT JUDGE

[6733]

MASSACHUSETTS CASUALTY INSURANCE COMPANY,
a Massachusetts Corporation,
Plaintiff-Appellant,

v.

Kenneth B. FORMAN,
Defendant-Appellee.

No. 74-1504.

United States Court of Appeals,
Fifth Circuit.

July 25, 1975.

Disability insurer filed suit to rescind and cancel policy, and insured counterclaimed for specific performance. Following remand, 469 F.2d 259, the United States District Court for the Southern District of Florida, at Miami, William O. Mehrtens, J., entered judgment in favor of insured, and insurer appealed. The Court of Appeals, Godbold, Circuit Judge, held that although incontestability clauses protected insured from rescission or cancellation of policy more than two years after its issuance by reason of false statements in application, including specific denial that he had ever had diabetes, where diabetes had first manifested itself almost a year before the policy became effective, disability resulting from the diabetes was never within the scope of policy coverage, under policy extending coverage with respect to "Sickness which first manifests itself during

the term of its policy"; and that incontestability clauses would not be applied to extend the policy coverage.

Reversed in part; affirmed, as modified, in part; and remanded.

1. Insurance — 454

Purpose of disability policy provision that coverage with respect to sickness applied to "Sickness which first manifests itself during the term of this policy" was to shelter insurer from claims arising from conditions which existed, and which were known by the insured to exist, before coverage commenced.

2. Insurance — 400.7, 454.1

Where diabetes, for which insured claimed disability benefits, had first manifested itself and had been diagnosed almost a year before the policy became effective, disability resulting from diabetes was not within the scope of policy coverage, and insured could not claim diabetes-related disability benefits by reason of incontestability provisions of the policy.

3. Insurance — 400.6

An incontestable clause in a disability policy does not preclude the insurer from defending on the ground that a particular disability was never within the policy coverage.

4. Insurance — 400.7

Statutorily required incontestable clause in disability policy, providing that after two years policy should become incontestable as to statements contained in the copy of the application, though protecting insured against cancella-

tion or rescission of the policy by reason of false denials in application that he had ever had diabetes, did not extend coverage of policy to diabetes-related disability which was never covered under the policy provisions by reason of having first manifested itself prior to the term of the policy. West's F.S.A. § 627.607.

5. Insurance — 400.7

Statutorily required "incontestable" clause in disability policy, providing that no claim for disability commencing after two years from date of issue of policy should be reduced or denied on ground that nonexcluded disease [6732]
"existed" prior to effective date of policy did not result in extension of coverage to disability with respect to disease which had not only existed but which had manifested itself and had been diagnosed prior to effective date of policy, which provided coverage with respect to "Sickness which first manifests itself during the term of this policy." West's F.S.A. § 627.607.

6. Insurance — 400.8

Incontestable clauses in disability policy precluded cancellation and rescission more than two years after date of issuance despite numerous and egregious false statements in application concerning prior illness, treatment and hospitalization. West's F.S.A. § 627.607.

7. Federal Civil Procedure — 2279

Statements made by court at attorney fee hearing, in colloquy with counsel during process of recalling to mind details of the case and of the merits decision, did not constitute "findings."

See publication Words and Phrases for other judicial constructions and definitions.

8. Insurance —601

Disability insurer was entitled to recover benefits that it had paid to insured under erroneous understanding that diabetic condition from which disability arose had initially manifested itself after the policy was issued.

9. Insurance —675

Attorney fees awarded insured under Florida statute in action on disability policy had to be reversed where major parts of judgment for insured on the merits was reversed. West's F.S.A. § 627.428.

Appeals from the United States District Court for the Southern District of Florida.

Before TUTTLE, GODBOLD and MORGAN, Circuit Judges.

GODBOLD, Circuit Judge:

The appellant, Massachusetts Casualty Insurance Company, filed suit against appellee Forman seeking to rescind and cancel a disability insurance policy it had issued to him and to recover $5,500 disability benefits already paid. Forman counterclaimed for enforcement of the policy. Following a nonjury trial, the District Court entered judgment in favor of Forman for $30,800 accrued benefits plus specific enforcement of the policy (which if Forman lived to life expectancy would produce total benefits of around $400,000), plus attorney fees of $65,000. Re-

lief to the company was denied. We reverse the award of benefits and of attorney fees, and direct that the policy continues in effect but without coverage for diabetes, the specific condition here in question. Also we hold that the company is entitled to repayment of the $5,500 previously paid.

Forman, a resident of Florida and formerly a chiropractor in New York, applied for the policy in October 1969. He had been hospitalized in New York September 7-20, 1968, and November 14-December 20, 1968. At least as early as December 2, 1968, his condition had been diagnosed as diabetes and he had been informed of the diagnosis. Despite these facts, now not disputed, the application for insurance contained numerous and egregious false statements concerning prior illness, treatment and hospitalization, including specific denials that the applicant had ever had diabetes.

After receipt of the application, the company procured an independent report from the Retail Credit Company verifying certain of Forman's factual statements concerning income and employment and supplying information [6738]
on his military service and general life style. This report contained virtually no information on Forman's health, aside from the statement "Health is good." Relying on the application and on the Retail Credit report, Massachusetts Casualty issued to Forman on November 20, 1969, a sickness and accident policy insuring against (emphasis added):

> (1) Accidental bodily injury occurring during the term of this Policy.

(2) Sickness which first manifests itself during the term of this policy.

Among the benefits were total disability payments of $1,000 per month for a period up to the life of the insured.[1]

On June 24, 1971, Forman executed a proof of loss and filed a claim alleging total disability as a result of diabetes which he claimed had been first diagnosed approximately one year earlier. The company began making disability payments, then discontinued them, and on November 16, 1971, filed suit against Forman seeking rescission and cancellation of the policy and return of benefits paid on the ground that in his application Forman had misstated his earned monthly income. In May 1972 the company learned of the preexistence of Forman's diabetic condition, and, with leave of court, amended its complaint to add this ground.

The District Court found that Forman had not misrepresented his earned income. This disposed of the sole ground for cancellation and denial of benefits asserted in the original complaint. With respect to the additional ground raised for the first time by the amended complaint, the court found that the incontestable clause of the policy became effective November 20, 1971, two years after the policy was issued. The portion of the policy headed "Incontestable" is as follows:

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[1]The parties assume without discussion that the Florida law applies, and we are given no facts on which we should hold otherwise. Therefore we apply Florida law, and where we find no law of that state the general body of insurance law.

> INCONTESTABLE: A. After this Policy has been in force for a period of two years during the lifetime of the Insured, it shall become incontestable as to the statements contained in the copy of the application. B. No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Both of the quoted provisions are required by F.S.A. § 627.607.

The court erred in what appears to have been its view that the effect of these provisions was to bring Forman's diabetes within the policy although it had "first manifested[ed]" itself before the policy was issued.

[1, 2] "First manifest" provisions shelter insurers from claims arising from conditions which exist, and which are known by the insured to exist, before coverage commences. See Continental Casualty Co. v. Robertson, 245 F.2d 604, 606-608 (CA5, 1957); Fuller v. Aetna Life Ins. Co., 259 F.2d 402 (CA5, 1958). In this case the condition for which Forman claimed benefits had "first manifested" itself almost a year before the policy became effective. Thus disability resulting from diabetes was never within the [6734]
scope of policy coverage, and Forman cannot now claim diabetes-related diasbility benefits unless the incontesta-

bility provisions of the policy caused this prior-existing illness to become covered. We conclude that they did not have that effect.

Incontestable clauses protect both insurer and insured. Winer v. New York Life Ins. Co., 140 Fla. 534, 190 So. 894 (1938). An incontestable clause safeguards an insured from excessive litigation many years after a policy has already been in force and assures him security in financial planning for his family, while providing an insurer a reasonable opportunity to investigate. Simpson v. Phoenix Mut. Life Ins. Co., 24 N.Y.2d 262, 267-269, 299 N.Y.S.2d 835, 839-841, 247 N.E.2d 655, 657-58 (1969). See also Prudential Ins. Co. of America v. Prescott, 130 Fla. 11, 176 So. 875, 878 (1937).

[3] The great weight of authority, including decisions of this court, holds that an incontestable clause in a disability policy does not deprive the insurer from defending on the ground that the particular disability was never within the policy coverage.

> Where loss is claimed by reason of disability covered by the policy, it is necessary, under the average policy, that the cause of such disability arise within the policy terms and after the insurance has been effected. This is a condition of liability, a condition of the insurance. . . . The incontestable clause does not apply under those circumstances, and there can be no recovery unless the cause of disability arose within the time designated.

1 Appleman, Insurance Law and Practice § 333 at 600 (1941). See also 18 Couch on Insurance § 72:16 at 79-80 (2d Ed. 1968). In United States v. Kaminsky, 64 F.2d 735 (CA5, 1933), a war risk insurance case, the incontestable clause was one imposed by federal statute. The beneficiary claimed benefits for a total disability commencing while the insured was in the army, and subsequent death benefits. This court held that the insurer was not barred from defending on the ground that the disability existed before the insured entered the service and was, therefore, not covered.[2] This result is but a precisely targeted application of the general rule that incontestable clauses do not cut off defenses going to coverage. Then Chief Judge Cardozo of the New York Court of Appeals has drawn this distinction:

> The provision that a policy shall be incontestable after it has been in force during the lifetime of the insured for a period of two years is not a mandate as to coverage, a definition of the hazards to be borne by the insurer. It means only this, that within the limits of the coverage the policy shall stand, unaffected by any defense that it was invalid in its inception, or thereafter became invalid by reason of a condition broken.

Metropolitan Life Ins. Co. v. Conway, 252 N.Y. 449, 452, 169 N.E. 642 (1930). Metropolitan Life refers to the opinion of this circuit in Sanders v. Jefferson Standard Life Ins. Co., 10 F.2d 143 (CA5, 1925), in which we had held that an incontestable clause which provided that the policy

[2]For a survey of other cases which, with respect to disability policies, permit the defense of preexisting disability despite incontestable provisions, see 13 A.L.R.3d 1383.

"shall be incontestable for any clause except for nonpayment of premiums" did not bar the insurer from asserting the exception to the double indemnity provision that ex-
[6735]
cluded death arising from bodily injury inflicted by another person. Other Fifth Circuit cases are: Metropolitan Life Ins. Co. v. Shalloway, 151 F.2d 548 (CA5, 1945), and Equitable Life Assur. Society v. First National Bank, 113 F.2d 272 (CA5, 1940) (incontestable clause does not bar inquiry into actual age for purposes of applying an age adjustment clause); Washington National Ins. Co. v. Burch, 270 F.2d 300 (CA5, 1959) (eligibility of the insured under a group policy and proper classification within the group may be inquired into despite an incontestable clause).

Here, where coverage is framed in terms of first manifestation and the misrepresentation of no prior history of diabetes goes to the heart of the definition of coverage, the principle of not permitting incontestability to broaden the scope of coverage attains especially strong force. There is little reason to decline to give it full effect. The policy of protecting the insured from belated discovery that he has no coverage loses much of its vitality.

[4] Our conclusion is not inconsistent with the two statutorily-required provisions of the incontestable clause in this policy. Subparagraph A provides that after two years the policy "shall become incontestable as to the statements contained in the copy of the application." Applying this plain and straightforward statement as written, it would appear to bar defenses that spring from — and only from — statements in the application. So read, subparagraph A has no application to the issue of whether

diabetes was outside the coverage of the policy because it first manifested before the policy was issued. Applying subparagraph A as written is consistent with the general law, discussed above, concerning interplay of incontestable clauses and questions of coverage.

[5] Subparagraph B provides:

> No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy (Emphasis added.)

This statutory clause only prohibits denials of claims based on the prior existence of a disease. Such denials are irrelevant here because a disease is covered no matter when it existed, so long as it was not first manifested prior to the policy date. This subparagraph B has no effective field of operation. Giving it some scope of operation by reading "existed" as "existed and manifested" goes beyond the language of the clause and is contrary to the general principle that incontestable clauses do not operate to extend coverage beyond that contracted for. Moreover, such a reading would not promote the purpose or policy of § 627.607. The statutory clause protects both parties from uncertainty where coverage turns on when a disease first existed, occurred or arose. Under such policies coverage may be uncertain even long after the policy was procured because a disease may exist but not be discoverable by

reasonable medical investigation. This clause resolves the uncertainty in favor of coverage beginning two years after the policy date. Where coverage turns on manifestation rather than existence, the insurance policy itself eliminates this uncertainty since manifestation is normally discoverable by reasonable medical investigation.

[6736]

Florida requires that incontestable clauses be included in several other types of insurance policies. The provision required in life insurance policies, §627.455, excludes from incontestability, at the option of the insurer, "provisions relative to benefits in event of disability." Section 627.463 provides that a clause in any life insurance policy providing for incontestability after a specified period "shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such clause." For group life insurance policies, § 627.560 requires a provision that "the validity of the policy shall not be contested, except for nonpayment of premium" after two years. The succeeding section, § 627.561, requires an additional provision that no statement made by an insured shall be used in any contest unless a copy of the instrument containing the statement has been furnished to him or to his beneficiary. Group disability policies must provide that in the absence of fraud misrepresentations for the purpose of effecting insurance shall not avoid the policy or reduce benefits unless contained in a written instrument, signed by the insured (or policyholder), a copy of which has been furnished to the policyholder or insured or beneficiary. § 627.657. Certain endowment and annuity

contracts, and industrial life policies, must contain a provision for incontestability after two years except for nonpayment of premiums, but at the option of the insurer the contract may also except provisions relating to benefits in the event of disability and provisions relating to accidental death. §§ 627.466 and 627.506. While these provisions do not present a wholly consistent pattern, they reveal at least that the legislature does not consider incontestability to be plenary in nature. Also, several sections provide for reduced benefits where the age or sex of the insured has been misstated, § 627.456 (life insurance), § 627.468 (annuity and endowment contracts), § 627.507 (industrial life policies), § 627.620 (disability policies). None of these sections purports to limit its application to the period of time during which the particular policy is contestable.[3]

Thus the law concerning incontestable clauses in general, the specific language of the incontestability provisions of this policy, and the Florida statutory scheme, lead us to the decision that the fact that Forman suffered from diabetes which had become manifest before the policy was issued excluded diabetes-related disability from coverage.[4]

[6, 7] We conclude, however, that the company is

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[3]See Metropolitan Life Ins. Co. v. Shalloway, 151 F.2d 548 (CA5, 1945), supra, and Equitable Life Assur. Society v. First National Bank, 113 F.2d 272 (CA5, 1940), supra, holding that an incontestable clause does not prevent giving effect to an age adjustment clause.

[4]Our approach has been through the rubric of incontestability because that is the one most often employed, and the two policy provisions that we have discussed were labeled "Incontestable." More accurately, part B is not an incontestable clause, properly so called, but a legislative expansion of coverage, having a field of operation wholly independent of statements made in the application. Under such an approach the result is the same.

not entitled to cancellation and rescission. A generalized incontestable clause, i.e., one providing that the policy is incontestable after a specified number of years except for nonpayment of premiums, bars assertion of fraudulent misstatements in an application as the basis for invalidity [6737]
of the policy. Winer v. New York Life Ins. Co., 130 Fla. 115, 177 So. 224 (1937) and 140 Fla. 534, 190 So. 894 (1938). That conclusion is even more clearly required where the clause is more specific, as is subparagraph A. Though incontestability is often cast in terms of defenses it applies also to efforts by the insurer to obtain the affirmative relief of cancellation and rescission. Prudential Ins. Co. v. Prescott, 115 Fla. 365, 156 So. 109 (1933); Winer, supra. Though the policy continues in effect it, of course, does not cover diabetes.[5]

[8] The company is entitled to the $5,500 of benefits that it paid to Forman under the erroneous understanding

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[5]The District Court found that Forman signed the application in blank and sent it to the agent, who filled in the answers called for. Despite repeated assertion to the contrary in Forman's brief, the District Court made no finding of fact as to who furnished to the agent the information embraced in the false answers. (Also, the court did not address itself at all to the several false statements in the representations to the medical examiner, which were a second part of the application, and were signed by Forman and attested by him to be true and correct.)

The trial court conducted a hearing on attorney fees several months after the decision on the merits. Forman elevates to the dignity of "findings" one or more informal statements made by the court at this hearing and arguably indicating that Forman did not supply the agent with the subject matter of the answers. The judge made the statements in colloquy with counsel during the process of recalling to his mind the details of the case and of the merits decision. These were not findings. If they had been we would hold them plainly erroneous. The evidence is overwhelming that the information contained in the misrepresentations originated with Forman.

that his diabetic condition had initially manifested itself after the policy was issued. Restatement of Restitution § 16 (1937).[6]

[9] The award of $65,000 attorney fees pursuant to F.S.A. § 627.428 must be reversed. It is for the District Court on remand to determine whether under the Florida law and the circumstances of this case there should be an award of fees.

Summarizing, we reverse the award to Forman of benefits and of attorney fees. We reverse the denial to the company of judgment for the benefits it had paid and direct entry of judgment for the company on this claim. We modify the denial to the company of cancellation and rescission to provide that although the policy is not cancelled it does not cover diabetes, and as modified affirm this part of the judgment.

Reversed in part; affirmed, as modified, in part; and remanded for further proceedings consistent with this opinion.

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[6]As previously noted Forman's claim, filed in June 1971, represented that diabetes had been diagnosed approximately one year earlier.

MASSACHUSETTS CASUALTY INSURANCE COMPANY,
a Massachusetts Corporation,
Plaintiff-Appellant,

v.

Kenneth B. FORMAN,
Defendant-Appellee.

No. 74-1504.

United States Court of Appeals,
Fifth Circuit.

Nov. 14, 1975.

Appeal from the United States District Court for the Southern District of Florida; William O. Mehrtens, Judge.

ON PETITION FOR REHEARING AND PETITION FOR REHEARING EN BANC

(Opinion 7-25, 1975, 5 Cir., 1975, 516 F.2d 425).

Before TUTTLE, GODBOLD and MORGAN, Circuit Judges.

PER CURIAM:

Neither Continental Casualty Co. v. Gold, 194 So.2d 272 (Fla., 1967), nor Continental Casualty Co. v. Fooden, 293 So.2d 758 (Fla.App., 1974), requires that we affirm the trial court. In neither of those cases was there evidence,

such as there is in the present case, that before the effective date of the policy the insured's condition, by reason of its disabling consequences, was a "sickness" as opposed to a mere "sympton" or a "disease."

The Petition for Rehearing is denied and no member of this panel nor Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35 Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 12), the Petition for Rehearing En Banc is denied.

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

October Term, 1974

No. 74-1504

D. C. Docket No. CA-71-1757
MASSACHUSETTS CASUALTY INSURANCE COMPANY,
a Massachusetts Corporation,
Plaintiff-Appellant,

versus

KENNETH B. FORMAN,
Defendant-Appellee.

Appeals from the United States District Court for the Southern District of Florida

Before TUTTLE, GODBOLD and MORGAN, Circuit Judges.

JUDGMENT

This cause came on to be heard on the transcript of the record from the United States District Court for the Southern District of Florida, and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, reversed in part; affirmed, as modified, in part; and that this cause be, and the same is hereby remanded to the said District Court for further proceeding consistent with the opinion of this Court;

It is further ordered that costs are to be taxed equally against plaintiff-appellant and defendant-appellee.

July 25, 1975

Issued as Mandate:

Supreme Court, U. S.
FILED
JAN 12 1976
MICHAEL RODAK, JR., CLERK

in the Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-886

KENNETH B. FORMAN,

Petitioner,

vs.

MASSACHUSETTS CASUALTY INSURANCE COMPANY,
a Massachusetts Corporation,

Respondent.

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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MIAMI REVIEW — 371-4853 — 377-3721

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in the
Supreme Court
of the
United States

OCTOBER TERM, 1975

NO._____

KENNETH B. FORMAN,

Petitioner,

vs.

MASSACHUSETTS CASUALTY INSURANCE COMPANY,
a Massachusetts Corporation,

Respondent.

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

KENNETH B. FORMAN, as Petitioner, seeks a writ of certiorari to review the decision and judgment

[SA: 1-14] of the United States Court of Appeals for the Fifth Circuit in an cause entitled MASSACHUSETTS CASUALTY INSURANCE COMPANY, Appellant vs. KENNETH B. FORMAN, Appellee, reported in 516 F2d 425, and the subsequent decision and judgment [A: 25-26] denying Appellee's Petition for Rehearing, wherein the judgment [R: 582-585] and Amendment to Final Judgment [R: 600-601] of the United States District Court for the Southern District of Florida was reversed in part; affirmed as modified, in part and remanded. We shall refer in this brief to matters included in Petitioner's Appendix thus [A:] and to matters included in the Respondent's Supplemental Appendix submitted with this brief thus [SA:]; all record references indicated thus [R:] are to the record on appeal below. All italics are in original text; text of opinions in bold-face are ours for emphasis unless otherwise stated.

STATEMENT OF THE CASE

On October 13, 1969, KENNETH B. FORMAN, hereinafter referred to as "FORMAN", made an application [R: 9, R: 20, R: 182-184] to MASSACHUSETTS CASUALTY INSURANCE COMPANY, hereinafter referred to as the "COMPANY", for issuance to him of an accident and health insurance policy which included [R: 20, R: 183] certain Declarations to Medical Examiner, both parts of which were signed by FORMAN in which he denied any prior history of diabetes. Relying upon said application [R: 182-184] the COMPANY issued to FORMAN the accident and health insurance policy [R: 7-20] for which he had applied, the effective date of the term of

which was November 20, 1969 [R: 7] which insured FORMAN "against loss resulting from —

> (1) Accidental bodily injury **occurring during the term of the policy** (hereinafter referred to as "such accidental bodily injury") or,
>
> (2) Sickness which **first manifests itself during the term of this policy** (hereinafter referred to as "such sickness"), to the extent hereinafter provided.

Said insurance policy contained a two-year incontestable clause in the form prescribed by Section 627.607 Florida Statutes. [R. 9]

On June 24, 1971, FORMAN executed a proof of loss and filed a claim [R: 29, Pl. Ex. 12] that he was totally disabled as result of diabetes, and that said sickness had commenced on February 19, 1970, and upon that claim, the COMPANY began making disability payments of $1,100.00 per month. On May 18, 1972, the COMPANY discovered for the first time [R: 181] that FORMAN had been confined as a patient of Dr. Maurice Dunst in a hospital in New York State, the first confinement commencing on September 7, 1968, and extending through September 20, 1968, and the second confinement commencing on November 14, 1968, extending through December 2, 1968 [R; 186-189,] during which FORMAN'S sickness had been diagnosed as diabetes mellitus. Dr. Maurice Dunst, FORMAN'S attending physician, testified [R: 437-465] that FORMAN was confined in Brookdale Hospital Medical Center in Brooklyn, New York, as his patient during the two periods mentioned above, during which his sickness was diagnosed as diabetes mellitus.

Later, during a deposition taken on January 19, 1973, [R: 211-229] FORMAN testified fully concerning his admission and confinement as a patient in Brookdale Hospital Medical Center for a period of approximately two weeks following each admission, making a total of approximately four weeks [R: 228-229] during which he was confined as a patient during which his sickness was diagnosed as diabetes mellitus.

On November 16, 1971, the COMPANY as Plaintiff, filed a Complaint against FORMAN, as Defendant, in the United States District Court for the Southern District of Florida, invoking jurisdiction upon the ground of diversity of citizenship [R: 1-20] to rescind and cancel said accident and health insurance policy upon the ground that in his application for said policy FORMAN had misrepresented the amount of his "monthly earned income", the only ground then known to the COMPANY, since at that time the COMPANY had not discovered FORMAN'S false representations in his application [R: 9, R: 20 and R: 182-184] that he had no prior history of diabetes. As soon as the COMPANY discovered said misrepresentations, it filed an application for leave to file an amendment [R: 189-191] asserting those misrepresentations as additional ground for rescission and cancellation, and on April 10, 1973 [R: 451] that application was granted, and on September 18, 1973, the Court entered an order [R: 558] that said amendment [R: 189-191] should **"relate back to the filing of the original complaint pursuant to Rule 15(c) Federal Procedure"**, and set the cause for trial, which resulted in a final judgment [R: 582-586; A: 1-6] and an amendment to said final judgment [R: 600-601; A: 7-8] from which the COMPANY appealed [R: 606] to the

United States Court of Appeals for the Fifth Circuit, which rendered the judgment [A: 27-28] which FORMAN, as Petitioner, seeks to review by writ of certiorari.

Petitioner's Statement of the Case

Petitioner's "Statement of the Case", includes the following:

> "The policy in issue resulted from defendant FORMAN'S action in the latter part of 1969, seeking health and accident disability insurance from one Allen Davis, an insurance agent in New York * * * **Davis mailed FORMAN a blank Massachusetts Casualty application form** (R. 19) **with instructions to sign where he, Davis, indicated and return it to him** in New York. (Trial Record References) **Thereafter Davis himself, without Forman supplying answers, completed the application** (Trial Record References) **dated October 13, 1969, and filed it with** the insurance company." (See: Petition, p. 5) * * * Nevertheless, **Forman asserted** at the same time that he had not supplied answers to the question on the insurance application." (See: Petition, p. 8)

The Court of Appeals for the Fifth Circuit, in its opinion, and judgment here sought to be reviewed, rejected [Footnote 5, p. 6738, SA: 13] this contention:

> "5. The District Court found that Forman signed the application in blank and sent it to the agent, who filled in the answers called for. Despite re-

peated assertion to the contrary in Forman's brief, the District Court made no finding of fact as to who furnished to the agent the information embraced in the false answers. (Also, the court did not address itself at all to the several false statements in the representations to the medical examiner, which were a second part of the application and were signed by Forman and attested by him to be true and correct.)

The trial court conducted a hearing on attorney fees several months after the decision on the merits. Forman elevates to the dignity of "findings" one or more informal statements made by the court at this hearing and arguably indicating that Forman did not supply the agent with the subject matter of the answers. The judge made the statements in colloquy with counsel during the process of recalling to his mind the details of the case and of the merits decision. These were not findings. If they had been we would hold them plainly erroneous. The evidence is overwhelming that the information contained in the misrepresentations originated with Forman."

We suggest that **the facts** as found and stated by the Court in the decision here sought to be reviewed **are the facts** proper for consideration here.

QUESTION PRESENTED

We shall re-state the question presented in the form stated by Petitioner's Counsel:

> "WHETHER THE FIFTH CIRCUIT HAS CONSTRUED FLORIDA STATUTE §627.607 SO AS TO REACH A RESULT DIRECTLY OPPOSITE TO AND CONFLICTING WITH CLEAR AND CONTROLLING RULINGS BY THE SUPREME COURT OF FLORIDA ON AN ASPECT OF STATE INSURANCE LAW HAVING MAJOR IMPORTANCE."

Said question arose out of the lower court's resolution of these two points:

First: The insuring agreements of the accident and health insurance policy [R: 7] read as follows:

> "* * * the COMPANY does hereby insure the above-named policy holder * * * against loss re-resulting from
>
> (1) Accidental bodily injury **occurring during the term of the policy** (hereinafter referred to as "such bodily injury") or,
>
> (2) Sickness which **first manifests itself during the term of this policy** (hereinafter referred to as "such sickness"), to the extent hereinafter provided."
>
> * * *

> "This policy is effective from 12 o'clock noon standard time on the policy date * * * the term specified in the policy schedule * * * Policy date: November 20, 1969."

The Court determined [Text 1, 2, p. 6734-6735] that FORMAN'S diabetes **"had first manifested itself** before the policy became effective", and therefore his claim for disability by reason of "such sickness" was not within the coverage of the policy.

Second: Said policy contained a provision, required by Section 627.607 Florida Statutes, quoted by the Court of appeals as follows:

> "B. No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

Did said provision, required by Section 627.607 Florida Statutes, bar the COMPANY from contesting FORMAN'S claim upon the ground that said claim was not covered by the policy? The Fifth Circuit answered "No" and held that the COMPANY was not barred from contesting FORMAN'S claim upon the ground that said claim was not covered by said policy.

We respectfully submit that the **QUESTION PRESENTED** and the points out of which it arose were an-

swered correctly in accordance with Florida law, controlling decisions of the Florida courts, which we shall review hereinafter.

First Point —
"First Manifest" Rule

In the case at bar, it was conclusively established by FORMAN's belated admissions [R: 295-298] that he had been confined as a patient of Dr. Maurice Dunst in Brookdale Hospital Medical Center in Brooklyn, New York, for a period of two weeks, from September 7, 1968, to September 20, 1968, and for a second period between November 14, 1968 and December 2, 1968, and during those two periods while he was confined as a patient in that hospital his sickness or physical condition was diagnosed by his attending physician as diabetes mellitus and at all times after December 2, 1968, FORMAN "knew and was aware of the fact that he was a diabetic, and that his condition had been diagnosed to be diabetes mellitus." [R: 296-297] It is equally certain that the policy term began on November 20, 1969.

The rule established in
Florida and the Fifth Circuit
followed in 22 other jurisdictions.

In a Note in 53 ALR 2d. 686, 689, and its continuation in the pocket-part, the rule established in Florida and the Fifth Circuit is stated, supported by decisions in 19 other jurisdictions as follows:

> "It is generally recognized that provisions in a health or hospital insurance policy requiring that

the illness or disease from which the assured suffers originate a specified time after the date of the policy to be within the policy coverage are strictly construed against the insurer, and the illness, disease, or disability will ordinarily be deemed to have its inception when it first becomes manifest or active or when there is a distinct symptom or condition from which one learned in medicine can with reasonable accuracy diagnose the disease."

Note: 53 ALR 2d. 686, 689

To the 19 jurisdictions listed in support of that rule, must be added the following:

(1) **Continental Casualty Company vs. Robertson** (CA-5-GA.) **245 F.2d. 604**

(2) **Continental Casualty Company v. Fooden** (Fla. App. 3- 1974) **293 So.2d. 758**, citing note **53 So.2d 686, 689;**

(3) **Boyle v. Springfield Life Insurance Co. 38 Fla. Supplement 84**, citing note **53 ALR 2d. 689**, affirmed in **Springfield Life Insurance Company v. Boyle** (Fla.App.4-1973) 272 **So.2d. 826**

(4) **Jack L. Turner v. Union Fidelity Life Insurance Co.** (Fla. App. 2 - Sept. 12, 1975) **319 So.2d. 588**, citing note **53 ALR 2d 686**

(5) **Time Insurance Company v. Arnold** (Fla. App. 1 - October 10, 1975) **319 So.2d. 638,** recognizing the rule stated in 53 ALR 2d 686.

(6) **Mutual Hospital Insurance Inc. v. Klapper** (Ind. 1972) **288 NE 2d 279**

(7) **Southards v. Central Plains Insurance Co.** (Kansas 1968) **201 Kan. 499, 441 P2d 808**

(8) **Ray v. Hospital Care Ass'n.** (1952) **236 NC** 562, 73 SE 2d 475

(9) **Randa v. Bear** (1957) **50 Wash. 2d 415, 312 P.2d 640**

Thus, in addition to the Florida and Fifth Circuit decisions, following the rule stated in **53 ALR 2d. 686, 689,** we have added five (5) other jurisdictions, making a total of 24 jurisdictions throughout the United States which follow the rule.

Counsel have cited on pages 11 and 12 of the Petition for certiorari statutes of twenty-eight (28) states and the District of Columbia, which Counsel say (p. 11) are at least in substance the same as Section 627.607 Florida Statutes, to indicate the importance of the question they seek to review. We have not read the statutes cited, but accepting Counsel's statement as correct, we call attention to the fact that the note in **53 ALR 2d. 686, 689** with the additional cases we have cited above, fourteen (14) of those twenty-eight (28) states follow the rule stated in 53 ALR 2d. 686, 689 which is also the rule established in Florida and the Fifth Circuit.

The Rule in the Fifth Circuit

In **Continental Casualty Company v. Robertson** (CA-5-Ga.) **245 F.2d 604,** (See — SA: 1-14) a polio policy **applied for on July 7, 1954,** and **effective on July 22, 1954,** contained this provision:

> "When any member of the family shall, by reason of poliomyelitis **which first manifests itself after the effective date of this policy,** require treatment commencing while this policy is in force . . . the Company will pay for the following items of expense . . ."

Robertson's infant daughter **became ill on July 18, 1954,** but her illness was not diagnosed by doctors as polio until **July 26, 1954,** which was **after the effective date of the** policy. The insurance company contended that the claim was not covered because the child became ill on July 18, 1954. The Fifth Circuit held that the disease **"first manifested itself"** when the doctors first diagnosed the illness as poliomyelitis, and therefore it was covered.

Judge CAMERON, speaking for the Court said:

> "* * * The crucial question is **when, during the days intervening between July 18th and July 26th, the illness 'manifested itself' to be polio.** * * *
>
> "The infant became ill July 18th, and a general practitioner was called in, who found a sore throat and fever and administered penicillin. The family doctor returned to town on the 19th

and relieved the physician first called, and the infant was brought to his office. He found the same symptoms present and gave a second injection of penicillin. She was brought back to his office on the 20th and, chiefly because she had not responded to the penicillin, she was taken to a hospital where other doctors were called into consultation. At that time she experienced difficulty in walking and the congestion in nose and throat persisted. All of the doctors, proceeding with the caution which ordinarily leads them to view all afflictions at that time of year as such, suspected that the illness might be polio; **but they were unable to diagnose it as polio because all of the symptoms then existing were commonly found in a number of other diseases.** But, although he had asked them 'many many times', **they did not advise Appellee that they diagnosed the child's illness as polio until July 26th. which was the first time the symptoms had become sufficiently pronounced to permit them to classify it with any degree of assurance.**

"The tendency of the Georgia law to emphasize the 'usual and common signification' of word meanings make dictionary definitions important in determining whether, as contended by appellant, the evidence required the court to hold, as a matter of law, that polio had manifested itself on or before July 22nd. The transitive verb 'manifest' is thus defined: 'To show plainly; to make to appear distinctly; to put beyond question or doubt; to display; exhibit; reveal; prove; evince, evidence.' The essential import of this

definition is to recognize the verb 'manifest' as embracing the concept of demonstrating plainly, distinctly, or beyond question.

"Appellant's argument is bottomed upon the contention that the policy before us would not impose liability upon the company if polio had its origin or inception on or prior to July 22nd. **The Company could have chosen language of such meaning, but it did not do so. It inserted a word possessing a more exacting connotation, one contemplating the advancement of the disease beyond the point of origin and to the state where its presence was plain, distinct or beyond question or doubt."**

The Florida Cases Follow the Fifth Circuit

Boyle v. Springfield Life Insurance Co., 38 Florida Supplement 84, affirmed in **Springfield Life Insurance Co.** vs Boyle (Fla. App. 4-1973) **272 So.2d 826**, (See — SA: 29-39) involved a hospitalization policy:

"* * * insuring against loss resulting from 'sickness' of any covered dependent contracted and commencing while the policy was in force, the term 'dependent' including any unmarried child between the ages of 14 days and 23 years inclusive and dependent upon the insured." [Text 84, 85]

The policy was issued **June 2, 1965**, and the application showed that the insured's wife was at that time ap-

proximately six months pregnant, and on July 5, 1965, a boy was born. The facts, and the applicable rule were stated by Judge WARREN as follows:

> "From the briefs of the parties it appears that from the plaintiff's point of view the question is whether the policy involved covers a child who was diagnosed and treated after reaching the age of 14 days, as having a congenital condition; or, as the defendant states it, whether or not the infant had a "sickness" which was "contracted and commenced" during the time the policy was in force as to him.
>
> It will be recalled that the policy insured against loss resulting from "sickness" of a covered dependent, such a dependent including an unmarried child between the ages of 14 days and 23 years inclusive.
>
> The principle applicable to this case is found in **53 ALR2d, Insurance — Inception of Sickness §3, p. 689,** as follows — "It is generally recognized that the provisions in a health or hospital insurance policy requiring that the illness or disease from which the assured suffers originate a specified time after the date of the policy to be within the policy coverage are strictly construed against the insurer, and **the illness, disease, or disability will ordinarily be deemed to have its inception when it first becomes manifest or active or when there is a distinct symptom or condition from which one learned in medicine can with reason-**

able accuracy diagnose the disease." See also Couch on Insurance 2d, §41:814, and Appleman 1A, Insurance Law and Practice §406.

In Couch it is said, "In consequence of the distinction between 'sickness' and 'disease,' there is coverage under a 'sickness' policy of a 'sickness' which first manifests itself during the period of the policy even though it is traceable to a diseased condition which antedated the policy, absent any element of fraud or breach of warranty or condition, etc., which would make the policy void or voidable. That is, it is generally recognized that provisions in a health or hospital insurance policy requiring that the illness or disease from which the insured suffers originate a specified time after the date of the policy to be within the policy coverage are strictly construed against the insurer, and the illness, disease, or disability will ordinarily be deemed to have its inception when it first becomes manifest or active, or when there is a distinct symptom or condition from which one learned in medicine can with reasonable accuracy diagnose the disease."

In Continental Casualty Company v. Gold, Fla., 194 So.2d 272, upon which both parties rely, the jury, which had been presented with conflicting evidence as to when the condition causing hospitalization first became manifest, found in favor of the claimant. The Supreme Court in affirming was inclined to believe that the weight of authority supported the trial court's instruc-

tion to the jury, which was to the effect that one is regarded as sick only when his diseased condition has advanced far enough to incapacitate him. In that case the court stated at page 275 — In 29 Am. Jur., Insurance, §1154, 301, the text reads:

> "The words 'sickness' and disease' are technically synonymous, but when given the popular meaning as required in construing a contract of insurance, 'sickness' is a condition interfering with one's usual activities, whereas disease may exist without such result; in other words, one is not ordinarily considered sick who performs his usual occupation, though some organ of the body may be affected, but is regarded as sick when such diseased condition has advanced far enough to incapacitate him." We believe this is the general rule that governs this case; it supports the trial judge's ruling. The insurer could have protected itself in the terms of the policy in this particular had it deemed it advisable, by limiting its liability solely to a "disease" originating after a certain time stated in the policy or by stipulating that it did not cover "sickness" whose symptoms appeared prior to the effective date of the policy. This it did not do. It used the term "sickness" interchangeably with "disease" in respect to the time of its liability and, as we have seen, this word connotes incapacitation to perform one's usual occupation. See again 29 Am.Jur., Insurance, §1154, page 301, to the effect that in a situa-

tion of this kind the construction of the policy should favor the insured. The text there reads in part:

> "In determining what losses are covered by policies insuring against losses on account of disease or sickness, the general rule that ambiguous or uncertain provisions will be construed most favorably to the insured is applied. * * *"

The court believes that the facts herein come within the Gold case above.

While Dr. Gluck on July 8, 1965, found a congenital cardiac defect, it was satisfactory, and the child was discharged to its home two days later, he having mild cyanosis at the time. On July 15th, when the examining physician next saw the child after its discharge, which was within a few days of the 14 days inclusive period under the policy, there was noted cyanosis on crying, but the rest of the examination was negative.

According to the mother, during his first month the child ate and slept well, reacted normally, was not on medication or restricted, and had no problems, other than turning a little blue when he cried.

It was well after 14 days from the child's birth that Dr. Gluck found the change in the child of considerably increased blueness on August 2nd,

> which led her to change her diagnosis from truncus arteriosos to transposition, to find that prognosis was poor and that it was likely that the infant would develop cardiac failure, and to suggest cardiac studies which, when she originally saw the baby, she did not think worth doing because she was not concerned about the baby. And it was the result of the cardiac studies on August 18th, confirming transposition, which induced the reference by her to the specialist in Texas. These facts brought the matter within the **Gold** case and the general statements of the law as found in ALR2d and Couch above. The sickness under the policy became active and a distinct changed condition appeared from which the heart specialist could diagnose the disease; the condition had commenced and had advanced far enough to incapacitate the child.

The BOYLE case was decided squarely upon the principle announced and applied in **Continental Casualty Company v. Robertson,** supra, that a "sickness" has its inception **not at the date of its medical origin in the body, but when it has advanced beyond the point of origin to such a point that one learned in medicine can with reasonable accuracy diagnose the disease.**

Continental Casualty Company v. **Fooden,** (Fla. App. 3-1974) **293 So.2d 759** (See: SA: 23-28) was a case in which the insured sought to recover benefits under a policy for disability which he alleged resulted from a paralysis of Fooden's left arm which first appeared following surgery to that arm on March 15, 1971, which had been performed to correct an insufficiency of the right carotid artery.

The Court **held** that although the insured had suffered from arteriosclerotic cardiovascular disease since approximately 1965, his disability resulting from the paralysis of his left arm was first diagnosed following that surgery and was covered by the policy. The Court said:

> **"According to the appellant, since plaintiff undeniably had heart disease some five years prior to the effective date of the insurance policy and in fact consulted a doctor within twelve months prior to the issuance of the policy, he does not fall within the definition of 'sickness' in the policy.**
>
> "However, this argument ignores language in the policy in the immediately preceding sentence: '"Sickness" wherever used in the policy means sickness or disease which causes disability covered by the policy commencing while the policy is in force as to the insured.'
>
> "In our view this case falls within the rule enunciated in Continental Casualty Company v. Gold, Fla.1967, 194 So.2d 272 that in determining what losses are covered by an insurance policy insuring against loss due to sickness or disease, ambiguous or uncertain provisions will be construed in favor of the insured.
>
> "[1] Similarly, **provisions in such policies which require that a sickness or disease originate at some specified time after the policy takes effect in order to provide coverage are strictly construed against the insurer.** See, Annot., 53

ALR2d 686, 689; Boyle v. Springfield Life Ins. Co., Cir.Ct. 1972, 38 Fla.Supp. 84, aff'd Springfield Life Ins Co. v. Boyle, Fla.App.1973, 272 So.2d 826.

"In Continental Casualty Company v. Gold, supra, the Supreme Court stated that the word 'sickness' connotes a diseased condition which has advanced far enough to incapacitate an individual from performing his usual activities.

"In this case, Dr. Spear testified that arteriosclerosis, which afflicted the plaintiff, is 'an inescapable part of aging' which everyone develops to some degree. Dr. Spear further described the disease as 'segmental' which at different times may affect certain vessels and involve only specific areas of the body.

"[2] **We think the evidence in this case establishes that the 'sickness' which disabled the plaintiff became active and was diagnosed by Dr. Spear after the policy became effective. The incapacity to plaintiff's left arm was not manifested until after the March 15th operation."**

Jack L. Turner v. Union Fidelity Life Insurance Company, (Fla.App. 2-September 12, 1975) 319 So.2d 588, which cites the note in 53 **ALR2d 686,** upon its facts is on all fours with the case at bar as a comparison will show:

Facts in Forman Case

The effective date of FORMAN's policy was November 20, 1969, and insured against loss resulting from "sickness" which first manifested itself during the term of said policy which commenced on November 20, 1969. In 1968, commencing on September 7, 1968, FORMAN became sick, and was confined as a patient in a hospital on two occasions extending to December 2, 1968, during which confinement, his attending physician diagnosed his "sickness" as diabetes mellitus. FORMAN made no claim that his "sickness" during 1968 was covered by the policy, but on February 19, 1970, which was "during the term" of said policy, FORMAN claimed to have become disabled as result of diabetes, the same physical condition or sickness from which he had suffered in 1968, and sought to recover benefits for the second "manifestation" of said sickness.

Facts in Turner Case

The effective dates of TURNER's two policies were May 11, 1971, and June 24, 1971, and excluded from coverage sickness from "heart trouble only if contracted more than six months after the effective dates of the policy." On November 9, 1971, Turner was hospitalized as result of a heart attack, and remained in the hospital until December 2, 1971, which was during and within the six months exclusionary period. Turner conceded there was no policy coverage for that heart attack, but on November 4, 1972, more than six months after the effective date of said policies, TURNER suffered a second heart attack caused by arteriosclerosis, the underlying cause of the first attack and sought to recover benefits for the second "manifestation" of said sickness.

The trial court entered judgment for the insurer, as did the Fifth Circuit in the case at bar. Judge SCHEB, speaking for the Court in the TURNER case said:

> "The trial court concluded that each of Turner's periods of disability was caused by 'heart trouble' contracted on November 9, 1971, within the six months exclusionary period. Judgment was entered in favor of the insuror, and Turner appeals.
>
> **"The undisputed medical evidence shows that Turner's second heart attack was a recurrent manifestation of an underlying coronary heart disease (arteriosclerosis) which manifested itself within six months of issuance of the policies. An illness, disease or disability ordinarily is deemed to have been 'contracted', i.e., to have its inception when it first becomes manifest or active. See 53 A.L.R.2d 686; 17 C.J.S. Contract p. 512 (1963).** The trial court, therefore, correctly determined **that the disability resulting from the second heart attack was a continuation of the 'heart trouble' which originally was contracted during the six months exclusionary period.**
>
> "Accordingly, the judgment of the trial court is affirmed."

Continental Casualty Company v. Gold (Sup.Ct.-1967) **194 So.2d 272** differs from the cases we have reviewed in several important respects: **First,** a study of that decision [SA: 15-22] does not show when, if ever, the insured's

physical condition, malady or disease was "diagnosed," nor is the nature or cause of her illness stated or shown. **Second,** the Supreme Court stated [SA: 20] that:

> "* * * the jury was presented with **conflicting evidence as to when the condition causing** [plaintiff's] **hospitalization first became manifest.**"

Third, the Court expressly recognized [SA: 21] that a provision limiting the insured's liability such as contained in the FORMAN policy in the case at bar would require a different result:

> "**The insurer could have protected itself** in the terms of the policy in this particular had it deemed advisable, **by limiting its liability solely to a 'disease' originating after a certain time stated in the policy or by stipulating that it did not cover 'sickness' whose symptoms appeared prior to the effective date of the policy. This it did not do.**"

In the case at bar, MASSACHUSETTS CASUALTY **did what the insurer did not do in the Gold case, it limited its liability to "sickness" which first manifests itself during the term of this policy;** and, we submit that having done so, the case at bar was not controlled by the **Gold case.**

Fourth, the Court held that the manner in which the case had been tried [SA: 21-22] precluded a reversal.

In the case at bar, the Respondent-insurer proved without controversy, the facts which the insurer had not proved in the **Gold** case: That is, that FORMAN was sick

and confined in a hospital as a patient for a period of approximately four weeks between September 3, 1968, and **December 2, 1968, and that during that period his sickness** was diagnosed by his physician as diabetes mellitus [R: 101; 228] from which **"a reasonable inference may be drawn,"** as the Court said in **Gold** [SA: 22], **"that these were the dates when** [FORMAN] **was incapacitated,"** that is in 1968 before FORMAN had even applied for the **policy.**

These authorities, we submit, supported the decision of the Fifth Circuit [A: 25-26] denying FORMAN's Petition **for Rehearing:**

"PER CURIAM:

"Neither Continental Casualty Co. v. Gold, 194 So.2d 272 (Fla., 1967), nor Continental Casualty Co. v. Fooden, 293 So.2d 758 (Fla.App., 1974), requires that we affirm the trial court. In neither of those cases was there evidence, such as there is in the present case, that before the effective date of the policy the insured's condition, by reason of its disabling consequences, was a 'sickness' as opposed to a mere 'symptom' or a 'disease.'

"The Petition for Rehearing is denied and no member of this panel nor Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35 Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 12), the Petition for Rehearing En Banc is denied."

Concluding our discussion of the First Point, we submit that Petitioner's contention that a direct conflict exists between the decision of the Fifth Circuit in the FORMAN case [SA: 1-14] and the decisions of the Courts of Florida in Continental Casualty Company v. Gold [SA: 15-22] and Continental Casualty Company v. Fooden [SA: 23-28] is without merit, and that the Fifth Circuit did not fail or refuse to comply with the Mandate of ERIE RY. CO. v. TOMPKINS, relied upon to invoke this Court's jurisdiction on certiorari.

Second Point — Incontestable Clause Does Not Bar Contest Upon Ground of No Coverage

The statutory incontestable provision of the FORMAN policy, required by Section 627.607 Fla. Statutes, as quoted by the Court of Appeals, reads as follows:

> "**INCONTESTABLE: A.** After this Policy has been in force for a period of two years during the lifetime of the Insured, it shall become incontestable as to the statements contained in the copy of the application. **B. No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.**"

Having decided upon the authorities which we have discussed, that FORMAN's claim for disability benefits

by reason of diabetes was not covered by the policy, the Fifth Circuit decided and held that said incontestable provision did not bar the insurer from contesting FORMAN's claim under said policy upon the ground that said claim was not within the coverage of said policy:

> "In this case the condition for which Forman claimed benefits had 'first manifested' itself almost a year before the policy became effective. **Thus disability resulting from diabetes was never within the scope of policy coverage, and Forman cannot now claim diabetes-related disability benefits unless the incontestability provisions of the policy caused this prior-existing illness to become covered. We conclude that they did not have that effect."**

Petitioner argues (Petition for Cert., pp. 15-16) to the contrary, contending that any contest of FORMAN's claim, **even upon the ground that said claim was never within the policy's coverage,** was excluded by said statutory incontestable provision. That contention has been resolved against Petitioner by the recent decision in **HOME LIFE INSURANCE COMPANY v. REGUEIRA** (Fla.App. 2-May 28, 1975) **313 So.2d 438** [SA: 44-52] in which the Court held that an incontestable policy provision required by **Section 627.560 Fla. Statutes,** did not bar the insurer's defense upon the ground that the policy holder's claim was not within the coverage of the policy:

> "We consider this day the question of whether an incontestability clause contained in a group life insurance policy bars the insurer from defending against a claim on the ground that the

insured was not an employee eligible for insurance under the terms of the policy. **It appears to be a case of first impression in Florida.**

* * *

The policy also contained the following incontestability clause as required by § 627.0409, F.S. 1965 (now § 627.560, F.S. 1973):

> " **'This policy shall be incontestable after two years from the date of issue, except for the non-payment of premiums.'**

"Appellant sought to defend the action on the grounds that the decedent was not indeed a full-time employee within the afore-quoted eligibility provisions. The trial judge, however, held that the defense was barred under the aforesaid incontestability clause, disallowed the defense and entered a final summary judgment in favor of plaintiff-appellee for the full benefits under the policy together with attorney's fees, interest and costs. We reverse.

"[1, 2] **At the outset we agree with the trial judge that appellant did not properly 'contest' the policy within the two-year limitation period of the incontestability clause.** Plaintiff-appellee did file the claim herein within that period, and appellant had indeed rejected it within that period. But the law is clear on the point that an insurer must 'contest' a policy by the invocation of judicial action, either by way of claim or de-

fense, within the limits prescribed in an incontestability clause or be forever barred thereby. Couch puts it this way:[1]

> " 'As a general rule, a clause in an insurance policy making it incontestable after a certain period imports the invoking of judicial action to cancel the policy, or to prevent its enforcement, either by a suit to that end, or by a defense to an action on the policy; in fact, such a clause can be taken advantage of in no other method than by a judicial contest to which the insurer and the insured, or their representatives or beneficiaries, are parties.'
>
> * * *
>
> " 'An incontestable clause included in a life policy as required by statute contemplates and intends to require the institution within the specified period of a proceeding in court to cancel the policy on account of original invalidity, or the filing within that period, in a suit brought on the policy, of an answer setting up a ground of original invalidity to defeat recovery.'

So if the defense sought to be interposed herein is one which must be raised within the two-year contestability period, such defense is barred. **We are of the view, however, that it is not such a defense; and it is here that we respectfully depart from the conclusion of the trial judge.**

"[3] **The threshold question in these cases involving applicability of an incontestability**

[1] 18 G. Couch, Insurance § 72.98 (2d ed. 1968).

clause is whether the claim of the insurer relates to the validity of the policy or whether it relates to limitations of coverage. If it relates to the former it is barred; if to the latter it is not."

This Florida decision is squarely in accord with the Fifth Circuit's decisions in **Sanders v. Jefferson Standard Life Ins. Co.** (CA-5-Miss.) **10 F.2d 143; Washington National Life Ins Co. v. Burch, 270 F.2d 300,** and other authorities cited in the **FORMAN** decision.

CONCLUSION ON QUESTION PRESENTED

The basis for the Petition for Certiorari in this case is the Petitioner's contention that **Massachusetts Casualty Insurance Company v. Kenneth B. Forman** (CA-5-Fla.) 516 F.2d 425, conflicts with **Section 627.607 Fla. Statutes** and also conflicts with the decisions of the Florida courts in **Continental Casualty Co. v. Gold** (Sup.Ct. Fla.) **194 So.2d 272,** and **Continental Casualty Co. v. Fooden,** (Fla.App. 3-1974) **293 So.2d 758,** which, it is argued, is a departure from the principle established in **Erie R. Co. v. Tomkins, 304 U.S. 64** sufficient to invoke this Court's jurisdiction upon certiorari. We respectfully suggest that Petitioner's contention is without merit in view of the controlling Florida decisions upon each of the two points out of which said QUESTION PRESENTED arises, none of which are cited nor discussed in said Petition for Certiorari. It is not contended that the decision of the Fifth Circuit sought to be reviewed is in conflict with **(1)** the Constitution of the United States; **(2)** any federal statute; **(3)** any decision of this Court or decision of another Federal Court of Appeal, and we submit that there is no basis for review by certiorari, and said Petition for Certiorari should therefore be denied.

REASONS FOR GRANTING THE WRIT

We have shown that **Massachusetts Casualty Insurance Company v. Forman** (CA-5-Fla. 1975) **516 F.2d 425,** is not in conflict with **Section 627.607, Fla. Statutes,** as exemplified by **Home Life Insurance Company v. Reguiera** (Fla.App. 2-May 28, 1975) **313 So.2d 438,** nor with the decisions in **Continental Casualty Co. v. Gold,** supra, and **Continental Casualty Co. v. Fooden, supra,** but on the contrary, the decision in the **FORMAN** case, and decisions of the Appellate Courts of Florida follow the rule adopted in 22 other State jurisdictions collected in 53 ALR2d 686, 689, particularly as exemplified by **Turner v. Union Fidelity Life Insurance Company** (Fla.App. 2-September 12, 1975) **319 So.2d 588; Time Insurance Company v. Arnold,** (Fla.App. 1-October 10, 1975) **319 So.2d 638; Continental Casualty Insurance Co. v. Fooden,** supra; and **Boyle v. Springfield Life Insurance Co.,** supra. These decisions demolish any contention that in the **FORMAN** case, the Court departed from the mandate of **ERIE RY. CO. v. TOMPKINS, 304 U.S. 64,** the only basis for the Petition for Certiorari.

We respectfully suggest that if, as we have shown, the decision in the FORMAN case does not conflict with Section 627.607 Fla. Statutes, nor with decisions of the

Florida Courts, there is no reason for granting the Writ, and respectfully submit that said Petition for Certiorari should be denied.

Respectfully submitted,

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Of Counsel

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that three (3) copies of the foregoing Brief in Opposition to Petition for Certiorari were served upon Burton Young and William L. Rogers of SNYDER, YOUNG, STERN, BARRETT & TANNENBAUM, P. A., 17071 West Dixie Highway, North Miami Beach, Florida 33160, Attorneys for Petitioner, Kenneth B. Forman, by mailing three (3) copies thereof to them by United States Mail, First Class Postage prepaid, pursuant to Rule 33 of this Court, this 9th day of January, 1976.

L. J. CUSHMAN
Of Counsel

Supreme Court, U. S.
FILED
JAN 12 1976
MICHAEL RODAK, JR., CLERK

in the Supreme Court of the United States

OCTOBER TERM, 1975

NO. 75-886

KENNETH B. FORMAN,

Petitioner,

vs.

MASSACHUSETTS CASUALTY INSURANCE COMPANY,
a Massachusetts Corporation,

Respondent.

RESPONDENT'S SUPPLEMENTAL APPENDIX TO RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR CERTIORARI

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MIAMI REVIEW — 371-4853 — 377-3721

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United States Court of Appeals,
Fifth Circuit.

No. 74-1504.

MASSACHUSETTS CASUALTY INSURANCE COMPANY
a Massachusetts Corporation, Plaintiff-Appellant,
v.

KENNETH B. FORMAN,
Defendant-Appellee.

July 25, 1975.

516 F.2d 425

Disability insurer filed suit to rescind and cancel policy, and insured counterclaimed for specific performance. Following remand, 469 F.2d 259, the United States District Court for the Southern District of Florida, at Miami, William O. Mehrtens, J., entered judgment in favor of insured, and insurer appealed. The Court of Appeals, Godbold, Circuit Judge, held that although incontestability clauses protected insured from rescission or cancellation of policy more than two years after its issuance by reason of false statements in application, including specific denial that he had ever had diabetes, where diabetes had first manifested itself almost a year before the policy became effective, disability resulting from the diabetes was never within the scope of policy coverage, under policy extending coverage with respect to "Sickness which first manifests itself during the term of its policy"; and that incontestability clauses would not be applied to extend the policy coverage.

Reversed in part; affirmed, as modified, in part; and remanded.

1. **Insurance — 454**

Purpose of disability policy provision that coverage with respect to sickness applied to "Sickness which first manifests itself during the term of this policy" was to shelter insurer from claims arising from conditions which existed, and which were known by the insured to exist, before coverage commenced.

2. **Insurance — 400.7, 454.1**

Where diabetes, for which insured claimed disability benefits, had first manifested itself and had been diagnosed almost a year before the policy became effective, disability resulting from diabetes was not within the scope of policy coverage, and insured could not claim diabetes-related disability benefits by reason of incontestability provisions of the policy.

3. **Insurance — 400.6**

An incontestable clause in a disability policy does not preclude the insurer from defending on the ground that a particular disability was never within the policy coverage.

4. **Insurance — 400.7**

Statutorily required incontestable clause in disability policy, providing that after two years policy should become incontestable as to statements contained in the copy of the application, though protecting insured against cancellation or rescission of the policy by reason of false denials in application that he had ever had diabetes, did not extend cov-

erage of policy to diabetes-related disability which was never covered under the policy provisions by reason of having first manifested itself prior to the term of the policy. West's F.S.A. § 627.607.

5. Insurance — 400.7

Statutorily required "incontestable" clause in disability policy, providing that no claim for disability commencing after two years from date of issue of policy should be reduced or denied on ground that nonexcluded disease "existed" prior to effective date of policy did not result in extension of coverage to disability with respect to disease which had not only existed but which had manifested itself and had been diagnosed prior to effective date of policy, which provided coverage with respect to "Sickness which first manifests itself during the term of this policy." West's F.S.A. § 627.607.

6. Insurance — 400.8

Incontestable clauses in disability policy precluded cancellation and rescission more than two years after date of issuance despite numerous and egregious false statements in application concerning prior illness, treatment and hospitalization. West's F.S.A. § 627.607.

7. Federal Civil Procedure — 2279

Statements made by court at attorney fee hearing, in colloquy with counsel during process of recalling to mind details of the case and of the merits decision, did not constitute "findings."

See publication Words and Phrases for other judicial constructions and definitions.

8. Insurance — 601

Disability insurer was entitled to recover benefits that it had paid to insured under erroneous understanding that diabetic condition from which disability arose had initially manifested itself after the policy was issued.

9. Insurance — 675

Attorney fees awarded insured under Florida statute in action on disability policy had to be reversed where major part of judgment for insured on the merits was reversed. West's F.S.A. § 627.428.

Appeals from the United States District Court for the Southern District of Florida.

Before TUTTLE, GODBOLD and MORGAN, Circuit Judges.

GODBOLD, Circuit Judge:

The appellant, Massachusetts Casualty Insurance Company, filed suit against appellee Forman seeking to rescind and cancel a disability insurance policy it had issued to him and to recover $5,500 disability benefits already paid. Forman counterclaimed for enforcement of the policy. Following a nonjury trial, the District Court entered judgment in favor of Forman for $30,800 accrued benefits plus specific enforcement of the policy (which if Forman lived to life expectancy would produce total benefits of around $400,000), plus attorney fees of $65,000. Relief to the company was denied. We reverse the award of benefits and of attorney fees, and direct that the policy continues in effect but without coverage for diabetes, the

specific condition here in question. Also we hold that the company is entitled to repayment of the $5,500 previously paid.

Forman, a resident of Florida and formerly a chiropractor in New York, applied for the policy in October 1969. He had been hospitalized in New York September 7-20, 1968, and November 14-December 20, 1968. At least as early as December 2, 1968, his condition had been diagnosed as diabetes and he had been informed of the diagnosis. Despite these facts, now not disputed, the application for insurance contained numerous and egregious false statements concerning prior illness, treatment and hospitalization, including specific denials that the applicant had ever had diabetes.

After receipt of the application, the company procured an independent report from the Retail Credit Company verifying certain of Forman's factual statements concerning income and employment and supplying information on his military service and general life style. This report contained virtually no information on Forman's health, aside from the statement "Health is good." Relying on the application and on the Retail Credit report, Massachusetts Casualty issued to Forman on November 20, 1969, a sickness and accident policy insuring against (emphasis added):

(1) Accidental bodily injury *occurring during* the term of this Policy.

(2) Sickness which *first manifests itself during* the term of this Policy.

Among the benefits were total disability payments of $1,000 per month for a period up to the life of the insured.[1]

On June 24, 1971, Forman executed a proof of loss and filed a claim alleging total disability as a result of diabetes which he claimed had been first diagnosed approximately one year earlier. The company began making disability payments, then discontinued them, and on November 16, 1971, filed suit against Forman seeking rescission and cancellation of the policy and return of benefits paid on the ground that in his application Forman had misstated his earned monthly income. In May 1972 the company learned of the preexistence of Forman's diabetic condition, and, with leave of court, amended its complaint to add this ground.

The District Court found that Forman had not misrepresented his earned income. This disposed of the sole ground for cancellation and denial of benefits asserted in the original complaint. With respect to the additional ground raised for the first time by the amended complaint, the court found that the incontestable clause of the policy became effective November 20, 1971, two years after the policy was issued. The portion of the policy headed "Incontestable" is as follows:

> INCONTESTABLE: A. After this Policy has been in force for a period of two years during the lifetime of the Insured, it shall become incontestable as to the statements contained in the copy of the application. B. No claim for loss incur-

[1]The parties assume without discussion that the Florida law applies, and we are given no facts on which we should hold otherwise. Therefore we apply Florida law, and where we find no law of that state the general body of insurance law.

> red or disability (as defined in the Policy) commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had *existed* prior to the effective date of coverage of this Policy.

Both of the quoted provisions are required by F.S.A. § 627.607.

The court erred in what appears to have been its view that the effect of these provisions was to bring Forman's diabetes within the policy although it had "first manifested[ed]" itself before the policy was issued.

[1, 2] "First manifest" provisions shelter insurers from claims arising from conditions which exist, and which are known by the insured to exist, before coverage commences. *See Continental Casualty Co. v. Robertson*, 245 F.2d 604, 606-608 (CA5, 1957); *Fuller v. Aetna Life Ins. Co.*, 259 F.2d 402 (CA5, 1958). In this case the condition for which Forman claimed benefits had "first manifested" itself almost a year before the policy became effective. Thus disability resulting from diabetes was never within the scope of policy coverage, and Forman cannot now claim diabetes-related disability benefits unless the incontestability provisions of the policy caused this prior-existing illness to become covered. We conclude that they did not have that effect.

Incontestable clauses protect both insurer and insured. *Winer v. New York Life Ins. Co.*, 140 Fla. 534, 190 So. 894 (1938). An incontestable clause safeguards an insured

from excessive litigation many years after a policy has already been in force and assures him security in financial planning for his family, while providing an insurer a reasonable opportunity to investigate. *Simpson v. Phoenix Mut. Life Ins. Co.*, 24 N.Y.2d 262, 267-269, 299 N.Y.S.2d 835, 839-841, 247 N.E.2d 655, 657-58 (1969). *See also Prudential Ins. Co. of America v. Prescott*, 130 Fla. 11, 176 So. 875, 878 (1937).

[3] The great weight of authority, including decisions of this court, holds that an incontestable clause in a disability policy does not deprive the insurer from defending on the ground that the particular disability was never within the policy coverage.

> Where loss is claimed by reason of disability covered by the policy, it is necessary, under the average policy, that the cause of such disability arise within the policy terms and after the insurance has been effected. This is a condition of liability, a condition of the insurance. . . . The incontestable clause does not apply under those circumstances, and there can be no recovery unless the cause of disability arose within the time designated.

1 Appleman, Insurance Law and Practice § 333 at 600 (1941). *See also* 18 Couch on Insurance § 72:16 at 79-80 (2d Ed. 1968). In *United States v. Kaminsky*, 64 F.2d 735 (CA5, 1933), a war risk insurance case, the incontestable clause was one imposed by federal statute. The beneficiary claimed benefits for a total disability commencing while the insured was in the army, and subsequent death benefits. This court held that the insurer was not barred from

defending on the ground that the disability existed before the insured entered the service and was, therefore, not covered.[2] This result is but a precisely targeted application of the general rule that incontestable clauses do not cut off defenses going to coverage. Then Chief Judge Cardozo of the New York Court of Appeals has drawn this distinction:

> The provision that a policy shall be incontestable after it has been in force during the lifetime of the insured for a period of two years is not a mandate as to coverage, a definition of the hazards to be borne by the insurer. It means only this, that within the limits of the coverage the policy shall stand, unaffected by any defense that it was invalid in its inception, or thereafter became invalid by reason of a condition broken.

Metropolitan Life Ins. Co. v. Conway, 252 N.Y. 449, 452, 169 N.E. 642 (1930). *Metropolitan Life* refers to the opinion of this circuit in *Sanders v. Jefferson Standard Life Ins. Co.*, 10 F.2d 143 (CA5, 1925), in which we had held that an incontestable clause which provided that the policy "shall be incontestable for any cause except for nonpayment of premiums" did not bar the insurer from asserting the exception to the double indemnity provision that excluded death arising from bodily injury inflicted by another person. Other Fifth Circuit cases are: *Metropolitan Life Ins. Co. v. Shalloway*, 151 F.2d 548 (CA5, 1945), and *Equitable Life Assur. Society v. First National Bank*, 113 F.2d 272 (CA5, 1940) (incontestable clause does not

[2]For a survey of other cases which, with respect to disability policies, permit the defense of preexisting disability despite incontestable provisions, see 13 A.L.R.3d 1383.

bar inquiry into actual age for purposes of applying an age adjustment clause); *Washington National Ins. Co. v. Burch*, 270 F.2d 300 (CA5, 1959) (eligibility of the insured under a group policy and proper classification within the group may be inquired into despite an incontestable clause).

Here, where coverage is framed in terms of first manifestation and the misrepresentation of no prior history of diabetes goes to the heart of the definition of coverage, the principle of not permitting incontestability to broaden the scope of coverage attains especially strong force. There is little reason to decline to give it full effect. The policy of protecting the insured from belated discovery that he has no coverage loses much of its vitality.

[4] Our conclusion is not inconsistent with the two statutorily-required provisions of the incontestable clause in this policy. Subparagraph A provides that after two years the policy "shall become incontestable as to the statements contained in the copy of the application." Applying this plain and straightforward statement as written, it would appear to bar defenses that spring from—and only from statements in the application. So read, subparagraph A has no application to the issue of whether diabetes was outside the coverage of the policy because it first manifested before the policy was issued. Applying subparagraph A as written is consistent with the general law, discussed above, concerning interplay of incontestable clauses and questions of coverage.

[5] Subparagraph B provides:

> No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy (Emphasis added.)

This statutory clause only prohibits denials of claims based on the prior existence of a disease. Such denials are irrelevant here because a disease is covered no matter when it existed, so long as it was not first manifested prior to the policy date. Thus subparagraph B has no effective field of operation. Giving it some scope of operation by reading "existed" as "existed and manifested" goes beyond the language of the clause and is contrary to the general principle that incontestable clauses do not operate to extend coverage beyond that contracted for. Moreover, such a reading would not promote the purpose or policy of § 627.607. The statutory clause protects both parties from uncertainty where coverage turns on when a disease first existed, occurred or arose. Under such policies coverage may be uncertain even long after the policy was procured because a disease may exist but not be discoverable by reasonable medical investigation. This clause resolves the uncertainty in favor of coverage beginning two years after the policy date. Where coverage turns on *manifestation* rather than existence, the insurance policy itself eliminates this uncertainty since manifestation is normally discoverable by reasonable medical investigation.

Florida requires that incontestable clauses be included in several other types of insurance policies. The provision required in life insurance policies, § 627.455, excludes from incontestability, at the option of the insurer, "provisions relative to benefits in event of disability." Section 627.463 provides that a clause in any life insurance policy providing for incontestability after a specified period "shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such clause." For group life insurance policies, § 627.560 requires a provision that "the validity of the policy shall not be contested, except for nonpayment of premium" after two years. The succeeding section, § 627.561, requires an additional provision that no statement made by an insured shall be used in any contest unless a copy of the instrument containing the statement has been furnished to him or to his beneficiary. Group disability policies must provide that in the absence of fraud misrepresentations for the purpose of effecting insurance shall not avoid the policy or reduce benefits unless contained in a written instrument signed by the insured (or policyholder), a copy of which has been furnished to the policyholder or insured or beneficiary. § 627.657. Certain endowment and annuity contracts, and industrial life policies, must contain a provision for incontestability after two years except for nonpayment of premiums, but at the option of the insurer the contract may also except provisions relating to benefits in the event of disability and provisions relating to accidental death. §§ 627.466 and 627.506. While these provisions do not present a wholly consistent pattern, they reveal at least that the legislature does not consider incontestability to be plenary in nature. Also, several sections

provide for reduced benefits where the age or sex of the insured has been misstated, § 627.456 (life insurance), § 627.468 (annuity and endowment contracts), § 627.507 (industrial life policies), § 627.620 (disability policies). None of these sections purports to limit its application to the period of time during which the particular policy is contestable.[3]

Thus the law concerning incontestable clauses in general, the specific language of the incontestability provisions of this policy, and the Florida statutory scheme, lead us to the decision that the fact that Forman suffered from diabetes which had become manifest before the policy was issued excluded diabetes-related disability from coverage.[4]

[6, 7] We conclude, however, that the company is not entitled to cancellation and rescission. A generalized incontestable clause, i. e., one providing that the policy is incontestable after a specified number of years except for nonpayment of premiums, bars assertion of fraudulent misstatements in an application as the basis for invalidity of the policy. *Winer v. New York Life Ins. Co.*, 130 Fla. 115, 177 So. 224 (1937) and 140 Fla. 534, 190 So. 894 (1938). That conclusion is even more clearly required where the clause is more specific, as is subparagraph A.

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[3]See Metropolitan Life Ins. Co. v. Shalloway, 151 F.2d 548 (CA5, 1945), supra, and Equitable Life Assur. Society v. First National Bank, 113 F.2d 272 (CA5, 1940), supra, holding that an incontestable clause does not prevent giving effect to an age adjustment clause.

[4]Our approach has been through the rubric of incontestability because that is the one most often employed, and the two policy provisions that we have discussed were labeled "incontestable." More accurately, part B is not an incontestable clause, properly so called, but a legislative expansion of coverage, having a field of operation wholly independent of statements made in the application. Under such an approach the result is the same.

Though incontestability is often cast in terms of defenses it applies also to efforts by the insurer to obtain the affirmative relief of cancellation and rescission. *Prudential Ins. Co. v. Prescott*, 115 Fla. 365, 156 So. 109 (1933); *Winer, supra.* Though the policy continues in effect it, of course, does not cover diabetes.[5]

[8] The company is entitled to the $5,500 of benefits that it paid to Forman under the erroneous understanding that his diabetic condition had initially manifested itself after the policy was issued. Restatement of Restitution § 16 (1937).[6]

[9] The award of $65,000 attorney fees pursuant to F.S.A. § 627.428 must be reversed. It is for the District Court on remand to determine whether under the Florida law and the circumstances of this case there should be an award of fees.

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[5]The District Court found that Forman signed the application in blank and sent it to the agent, who filled in the answers called for. Despite repeated assertion to the contrary in Forman's brief, the District Court made no finding of fact as to who furnished to the agent the information embraced in the false answers. (Also, the court did not address itself at all to the several false statements in the representations to the medical examiner, which were a second part of the application, and were signed by Forman and attested by him to be true and correct.)

The trial court conducted a hearing on attorney fees several months after the decision on the merits. Forman elevates to the dignity of "findings" one or more informal statements made by the court at this hearing and arguably indicating that Forman did not supply the agent with the subject matter of the answers. The judge made the statements in colloquy with counsel during the process of recalling to his mind the details of the case and of the merits decision. These were not findings. If they had been we would hold them plainly erroneous. The evidence is overwhelming that the information contained in the misrepresentations originated with Forman.

[6]As perviously noted Forman's claim, filed in June 1971, represented that diabetes had been diagnosed approximately one year earlier.

Summarizing, we reverse the award to Forman of benefits and of attorney fees. We reverse the denial to the company of judgment for the benefits it had paid and direct entry of judgment for the company on this claim. We modify the denial to the company of cancellation and rescission to provide that although the policy is not cancelled it does not cover diabetes, and as modified affirm this part of the judgment.

Reversed in part; affirmed, as modified, in part; and remanded for further proceedings consistent with this opinion.

CONTINENTAL CASUALTY COMPANY,
Appellant,
v.
EVELYN GOLD, Appellee.

No. 35480

Supreme Court of Florida,

Jan. 6, 1967.

194 So.2d 272

Rehearing Denied Feb. 14, 1967.

Action on hospital policy. The Civil Court of Record, Dade County, Boyce F. Ezell, J., rendered judgment for insured and insurer appealed and District Court of Appeal, Third District, transferred. The Supreme Court, Ervin, J., held that statute providing that upon rendition of judgment against insurer in favor of insured or beneficiary under policy executed by insurer, insured or beneficiary shall recover reasonable attorney fee does not deny insurance companies due process of law and equal protection of law, and under policy providing coverage for sickness commencing after policy has been in effect 30 days, word "sickness" connotes incapacity to perform one's usual occupation and sickness does not commence when earliest symptoms of malady appear.

Affirmed.

O'Connell, J., dissented in part.

1. Constitutional Law — 248

Insurance — 4.1

Penalties — 2

Statute providing that upon rendition of judgment against insurer in favor of insured or named beneficiary under policy executed by insurer the insured or beneficiary shall be awarded reasonable attorney fee does not impose unconstitutional penalty upon insurance companies and does not violate equal protection of law by failing to equalize burdens between insurance companies dealing in surety bonds under similar conditions and circumstances. F.S. A. § 627.0127.

2. Insurance — 467.5

Under hospital policy providing specified benefits for sickness commencing after policy has been in effect 30 days, word "sickness" connotes incapacity to perform one's usual occupation and does not mean appearance of earliest symptoms of malady.

See publication Words and Phrases for other judicial constructions and definitions.

3. Insurance — 146.7(1)

Construction of ambiguous policy provisions should favor the insured.

4. **Appeal and Error — 1010(1)**

Under policy effective April 15, 1964, providing specified benefits for sickness commencing after policy had been in effect 30 days, where insured and insurer stipulated that insured was hospitalized June 9, 1964, and insurer failed to produce evidence that insured was incapacitated before date of hospitalization, finding that insured's sickness commenced 30 days after policy became effective was not disturbed.

Henry Burnett and Fowler, White, Gillen, Humkey & Trenam, Miami, for appellant.

Talburt & Kubicki, Miami, for appellee.

ERVIN, Justice.

This appeal was transferred here by the District Court of Appeal, Third District, pursuant to F.A.R. 2.1, subd. a(5) (d), 31 F.S.A., because the trial court passed on the validity of F.S. § 627.0127, F.S.A. We accept jurisdiction.

Evelyn Gold, the Appellee, sued Continental Casualty Company, the Appellant, in the Civil Court of Record of Dade County on a hospital policy issued by Appellant for certain benefits arising from her hospitalization on June 9th and 10th, 1964. The policy, effective April 15, 1964, provided specified benefits for "injury or sickness." Appellee's claim was for "sickness." Sickness covered by the policy is sickness commencing after the policy had been in effect thirty days.

The sole issue at trial was whether plaintiff Evelyn Gold's sickness commenced thirty days or more subsequent to the effective date of the policy. Plaintiff testified she had symptoms of severe backaches and frequent urination which resulted in her undergoing medical examination and consultation that lead to her hospitalization on June 9 and 10, 1964. She said the symptoms commenced approximately May 18, 1964. The hospital records reflect plaintiff stated that for the last several months she had been having vaginal discomfort and pain in the lower back. The treating physician reported to the hospital at the time of her admission that plaintiff had noticed said symptoms about "two months ago."

The trial judge instructed the jury that one is regarded as sick only when his diseased condition has advanced far enough to incapacitate him.

The jury after deliberating for a time returned to the courtroom to inquire when the testimony indicated plaintiff had last worked on her job. The inquiry was not answered by the trial judge because of the absence of any testimony on this point prior to the time the jury retired to consider its verdict. The jury returned to the jury room and rendered its verdict in favor of plaintiff. Final judgment in her favor ensued.

In the proceedings in the trial court the Appellant insurer preserved two points for appeal, viz.: (1) Is proof of incapacity from work a prerequisite to prove sickness? (2) Is F.S. § 627.0127, F.S.A., pertaining to assessment of attorney's fees against an insurer, unconstitutional?

* * *

Under Point 1 Appellant contends the trial court erred in giving the jury the following instruction over defendant's (Appellant's) objection:

> "• • • While the word 'sickness' is technically synonymous with such words as 'disease' it is popularly differentiated in this way: One is not ordinarily considered sick who performs his usual occupation, though some organ of the body may be affected; he is regarded as sick, when that diseased condition has advanced far enough to incapacitate him. • • •" United Security Life Insurance Co. v. Sikes, 40 Ala.App. 677, 122 So.2d 289, p. 293.

The pertinent provision of the hospital policy reads:

> " 'Sickness' wherever used in this policy means sickness or disease contracted and commencing after this policy has been in force for not less than thirty days after its effective date as to the person whose sickness is the basis of claim and resulting in loss covered by this policy."

With the foregoing in mind we note the sole factual issue to be determined at trial was whether the sickness involved was contracted and commenced thirty days after the effective date of the policy, or more specifically, whether it was contracted and commenced subsequent to May 15, 1964. The plaintiff testified the symptoms resulting in medical consultation and subsequent surgery commenced approximately May 18, 1964, but the hospital records in two instances reflected in fact that such symptoms commenced two or more months prior to June 9, 1964, which would

have been April 9, 1964 or before. Accordingly, the jury was presented with conflicting evidence as to when the condition causing hospitalization first became manifest. The Appellant complains that the foregoing quoted instruction effectively removed from the jury's consideration the question of whether the plaintiff's sickness under the policy occurred thirty days after the policy's effective date, since it was told as a matter of law plaintiff's sickness did not commence until she had in fact become incapacitated from performing her usual occupation. The issue then is one of correct definition of "sickness" as used in the policy. If it means that plaintiff's sickness could have commenced when the earliest symptoms of her malady appeared which were noted in the treating physician's reports to the hospital and reflected in its records, viz., that her symptoms commenced two or more months prior to June 9, 1964, then the instruction should not have been given. Absent the instruction the jury would have been at liberty to find that plaintiff's "sickness" occurred prior to the time she was incapacitated to perform her usual occupation and that the policy did not apply.

We note from the briefs and our studies that there is a conflict of authorities pertaining to this particular issue. However, we are inclined to believe that the weight of authority supports the trial court's instruction.

[2, 3] In 29 Am.Jur., Insurance, § 1154, 301, the text reads:

"The words 'sickness' and 'disease' are technically synonymous, but when given the popular meaning as required in construing a contract of insurance, 'sickness' is a condition interfering with one's usual activities, whereas

disease may exist without such result; in other words, one is not ordinarily considered sick who performs his usual occupation, though some organ of the body may be affected, but is regarded as sick when such diseased condition has advanced far enough to incapacitate him." We believe this is the general rule that governs this case; it supports the trial judge's ruling. The insurer could have protected itself in the terms of the policy in this particular had it deemed it advisable, by limiting its liability solely to a "disease" originating after a certain time stated in the policy or by stipulating that it did not cover "sickness" whose symptoms appeared prior to the effective date of the policy This it did not do. It used the term "sickness" interchangeably with "disease" in respect to the time of its liability and, as we have seen, this word connotes incapacitation to perform one's usual occupation. See again 29 Am.Jur., Insurance, § 1154, page 301, to the effect that in a situation of this kind the construction of the policy should favor the insured. The text there reads in part:

> "In determining what losses are covered by policies insuring against losses on account of disease or sickness, the general rule that ambiguous or uncertain provisions will be construed most favorably to the insured is applied. * * *"

[4] Finally, we are not inclined to reverse the cause because there was no precise proof when plaintiff last worked on her job. True, this point disturbed the jury and it returned to the courtroom to ascertain what the evidence disclosed thereon. It found there had been no evidence submitted by either of the parties before they rested their cases concerning when the plaintiff last worked on her job. However, plaintiff did prove she was hospitalized on June

9th and 10th, 1964 and a reasonable inference may be drawn therefrom that those were the dates when she was incapacitated. Moreover, the defendant could have cross-examined her on the subject or submitted evidence of its own to bring out that she was incapacitated sooner than June 9th and 10th (in fact, the transcript shows the parties stipulated plaintiff was hospitalized June 9, 1964—Tr. 53), but the record of the trial discloses that the defendant did neither (Tr. 55, et seq.). Moreover, the defendant did not make any defensive motion during the course of the trial based upon the subject of the jury's said inquiry.

Affirmed.

THORNAL, C. J., and THOMAS, ROBERTS, DREW and CALDWELL, JJ., concur.

O'CONNELL, J., concurs in part and dissents in part.

O'CONNELL, Justice (concurring in part and dissenting in part).

I concur in that part of Mr. Justice Ervin's opinion holding F.S. Sec. 627.0127, F.S.A. to be constitutional. I dissent from the remainder of the opinion.

District Court of Appeal of Florida,
Third District.

No. 73-713.

CONTINENTAL CASUALTY COMPANY,
a foreign corporation, Appellant,
v.

Harry J. FOODEN, Appellee.

April 23, 1974.

293 So.2d 758

Rehearing Denied May 21, 1974.

Insured brought action against insurer to recover on disability policy. The Circuit Court, Dade County, Milton Friedman, J., rendered judgment in favor of insured, and insurer appealed. The District Court of Appeal, Hendry, J., held that insured's disability to left arm fell within definition of "sickness" of disability policy and was covered by policy.

Affirmed.

1. **Insurance — 146.7(6)**

Provisions in a disability policy requiring that a sickness or disease originate at some specified time after policy takes effect in order to provide coverage are strictly construed against the insurer.

2. Insurance — 454.2

Even though insured had heart disease five years prior to effective date of disability policy and consulted physician 12 months prior to issuance of policy which excluded from coverage a sickness resulting from a preexisting condition and which defined "pre-existing condition" as a condition for which medical treatment was recommended by physician 12 months prior to insurance's effective date and defined "sickness" as a disease which causes disability, where insured's heart problems were attributable to aging and insured's disability to his left arm arose after operation when piece of ulcerated material broke loose within artery and traveled to insured's brain and insured came out of surgery with paralysis of arm, insured's sickness fell within definition of "sickness" in policy and was covered by policy.

Fowler, White, Humkey, Burnett, Hurley & Banick and A. Blackwell Stieglitz, Miami, for appellant.

Henry, Stroemer & Harrington and Robert E. Brandt, Miami, for appellee.

Before CARROLL, HENDRY and HAVERFIELD, JJ.

HENDRY, Judge.

This is an appeal by Continental Casualty Company from an adverse final judgment on a disability insurance contract.

Plaintiff, **Harry J. Fooden, sued Continental to recover benefits under a policy issued by the latter on December 4, 1969. The plaintiff claimed a total disability resulting from surgery to correct an insufficiency of the right carotid artery. The operation was performed on March 15, 1971** by Dr. Harold Spear, who on September 18, 1970 also had performed a left femoral endarterectomy on the plaintiff. At the time of the first operation, Dr. Spear had discovered a moderate degree of carotid insufficiency, however the doctor did not think it warranted surgery at that time.

The record reveals that plaintiff's heart problems were first experienced approximately in 1965. Plaintiff suffers from arteriosclerotic cardiovascular disease.

On November 12, 1969, less than one month prior to the issuance of the insurance policy, the plaintiff consulted Dr. Robert Bass who tentatively diagnosed a right carotid insufficiency and ordered an arteriogram. The arteriogram was "normal." Plaintiff's next consultation was with Dr. Robert Willner on May 30, 1970 who eventually referred him to Dr. Spear on August 7, 1970 when the plaintiff complained of pain in his left leg.

Dr. Spear testified that during the March 15th operation a piece of ulcerated material apparently broke loose within the carotid artery and traveled to plaintiff's brain. As a result, plaintiff came out of surgery with a paralysis of his left arm. The record contains the following testimony by Dr. Spear:

> "Q. . . . As a result of your care and treatment of this patient, do you have an opinion, based

upon reasonable medical certainty or probability, as to whether he [the plaintiff] is disabled from the conditions for which you treated him?
"A. He is disabled from the standpoint of his stroke problem. When last we saw him, he obviously, had residual stroke problems.

"Q. Are we talking about the stroke which he suffered some six years prior to the time you saw him?
"A. No. I am talking about the disability primarily of the left arm which he sustained after the surgery of March 15, 1971."

Based upon the medical records and testimony submitted by deposition, and memoranda of law from counsel, the trial court entered judgment in favor of plaintiff for $9,600 plus costs and attorney's fees.

Appellant argues that there was no evidence from which the court could have concluded that the plaintiff's disability arose from anything other than a pre-existing condition as it was defined in the policy.

The policy provides that "sickness" as defined therein shall not mean a sickness or disease caused by or resulting from a pre-existing condition.

Pre-existing condition is defined in the policy as "a condition for which medical treatment was rendered or recommended by a current licensed physician or surgeon within 12 months prior to the effective date of insurance as to the insured. A condition shall no longer be considered pre-existing after the lapse of a period of twelve consecu-

tive months commencing and ending after the effective date of the insurance as to the Insured during which period there has been no medical treatment rendered or recommended for such condition."

According to the appellant, since plaintiff undeniably had heart disease some five years prior to the effective date of the insurance policy and in fact consulted a doctor within twelve months prior to the issuance of the policy, he does not fall within the definition of "sickness" in the policy.

However, this argument ignores language in the policy in the immediately preceding sentence: " 'Sickness' wherever used in the policy means sickness or disease which causes disability covered by the policy commencing while the policy is in force as to the insured."

In our view this case falls within the rule enunciated in Continental Casualty Company v. Gold, Fla.1967, 194 So.2d 272 that in determining what losses are covered by an insurance policy insuring against loss due to sickness or disease, ambiguous or uncertain provisions will be construed in favor of the insured.

[1] Similarly, provisions in such policies which require that a sickness or disease originate at some specified time after the policy takes effect in order to provide coverage are strictly construed against the insurer. See, **Annot., 53 ALR2d 686, 689; Boyle v. Springfield Life Ins. Co., Cir. Ct. 1972, 38 Fla.Supp. 84, aff'd Springfield Life Ins. Co. v. Boyle, Fla. App. 1973, 272 So.2d 826.**

In Continental Casualty Company v. Gold, supra, the Supreme Court stated that the word "sickness" connotes a diseased condition which has advanced far enough to incapacitate an individual from performing his usual activities.

In this case, Dr. Spear testified that arteriosclerosis, which afflicted the plaintiff, is "an inescapable part of aging" which everyone develops to some degree. Dr. Spear further described the disease as "segmental" which at different times may affect certain vessels and involve only specific areas of the body.

[2] **We think the evidence in this case establishes that the "sickness" which disabled the plaintiff became active and was diagnosed by Dr. Spear after the policy became effective. The incapacity to plaintiff's left arm was not manifested until after the March 15th operation.**

Therefore, for the reasons stated and upon the authorities cited, the judgment appealed is affirmed.

Affirmed.

Circuit Court, Broward County,

No. 68-2931.

BOYLE v. SPRINGFIELD LIFE INSURANCE CO.

March 21, 1972.

38 Fla. Supplement 84

Plaintiff's insurance policy covered loss resulting from "sickness" of any dependent including an unmarried child between the ages of 14 days and 23 years. His wife gave birth to a boy with a defective heart, two months later a specialist operated on him.

He filed suit after the company rejected his claim on the ground that the condition requiring medical attention was congenital and therefore excluded under the provision excluding coverage until the child reached 14 days of age.

The circuit court, Warren, J., entered judgment for the plaintiff, with attorney's fees and costs.

Three days after the boy's birth a specialist found a congenital heart defect, but it was satisfactory and he was discharged to his home two days later, for a month he ate and slept well, reacted normally, was not on medication or restricted. Some time after 14 days from his birth the specialist determined that he was worse, changing the diagnosis from truncus arteriosis to transposition, and required surgery.

In consequence of the distinction between "sickness", which is ordinarily incapacitating, and "disease", there is coverage under a "sickness" policy of a "sickness" which first manifests itself during the period of the policy even though it is traceable to a diseased condition which antedated it.

Affirmed without opinion by the Fourth District Court of Appeal on January 29, 1973.

Francis D. O'Connor and Harry G. Carrott of Morgan, Carrott & O'Conner, Fort Lauderdale, for the plaintiff.

Francis A. C. Sevier of Stephens, Magill, Thornton & Sevier, Miami, for the defendant.

LAMAR WARREN, Circuit Judge.

Final judgment: **This cause involves the construction of an insurance policy insuring against loss resulting from "sickness" of any covered dependent contracted and commencing while the policy was in force,** the term "eligible dependent" including any unmarried child between the ages of 14 days and 23 years inclusive and dependent upon the insured.

Plaintiff filed his complaint against the defendant insurance company alleging that after the issuance of a policy of insurance a child was born to plaintiff, who was covered under the policy as a dependent; that a claim for medical expenses was filed which was rejected on the ground that the condition requiring medical attention was congenital, and therefore excluded under a policy provision

excluding coverage until the child reached 14 days of age, and plaintiff requested a judgment declaring his rights under the policy.

In its answer, defendant generally denied the allegations of the complaint, and alleged that there was no coverage for the child for the loss claimed because he did not become a covered dependent until he reached the age of 14 days, and that he was diagnosed as having a congenital transposition of the great vessels of the heart, a congenital heart disease.

The defendant issued the policy on June 2, 1965, the application attached to the policy showing that insured's wife was at the time approximately six months pregnant, and on July 5, 1965, the pregnancy resulted in the birth of a boy. On July 7th the attending physician, according to his deposition, noted that the baby appeared dusky (cyanotic) while crying and he decided that the baby had something wrong with his heart, a congenital heart defect, the duskiness implying to him that there was a cardiac condition that was not supplying enough blood to the skin on exertion; that he called for a consulting cardiologist, Dr. Regina Gluck, whose critical impressions were that of truncus arteriosus or Taussing transposition, with which impressions the witness agreed; that cardiograms taken on July 5th and July 8th were abnormal, that the progress notes showed that the condition on discharge to home on July 10th was fair to poor, and on the face sheet of the chart, unimproved; that on July 15th, when he next saw the child after discharge, he noted cyanosis when crying, but the rest of the examination was negative, and he next saw the child on August 12th, although he received Dr. Gluck's letter to him of August 4th and might have been

in discussion with her; that Dr. Gluck and he had decided that the baby had a congenital defect, and they recommended that after discharge that the cardiac condition be followed up; he told the mother that the baby had a serious congenital heart defect and that a cardiac study should be done, but not at this time, and he advised the mother to treat him normally; and that Dr. Gluck and he concurred in referring the child to a specialist in Texas, who undertook surgical procedures on September 1, 1965.

Dr. Gluck, the cardiac consultant, testified by way of deposition that she first saw the baby on July 8, 1965, and she thought that he had a congenital cardiac defect, which was satisfactory, and that the baby should be discharged, with a re-evaluation of its cardiac status in a month; she noted it had some mild cyanosis and the original x-ray gave the impression that there was enlargement of the heart. Her diagnosis on discharge on July 10, 1965, was congenital cardiac anomaly probably truncus arteriosos, however, in an August 9th letter she stated the baby probably had a transposition of the great vessels of the Taussig-Bing type, because she had seen the baby on August 2nd and there had been a change, increased blueness, in the baby's condition which did not "embarass" the child; the circulation was compensated for, so the baby's cardiac status was satisfactory. The baby was not in cardiac failure and was not having any problems such as feeding, and that was what she meant by "embarassing." Tests on August 18th confirmed her earlier diagnosis of transposition, but there never was an emergency that required surgery right then and there. On September 1st elective palliative surgery, to help the condition, was performed in Texas. Thereafter, the witness saw the child on an intermittent basis without any problems until January, 1967, when

secondary surgery was performed, and she saw him on a regular basis until further surgery in September, 1968, which was also successful. In May, 1971, he received a conversion procedure, and the child was again all right.

On August 4, 1965, Dr. Gluck wrote (letter attached to her deposition) the attending physician that on August 2nd, at the time of a cardiac checkup, the mother reported that he had been well, taking his formula as well as solid food readily; that although his blueness had increased, the respirations were normal, and he had been noticed to perspire a good deal with activity. The witness at that time found the infant well nourished, cyanosis increased with crying, respirations normal, heart enlarged on percussion, no evidence of cardiac failure, and she did not consider it necessary to repeat the fluoroscopic examination or the electrocardiogram. After noting a considerable increase in cyanosis, and changing her diagnosis, she believed prognosis was poor and that it was likely the infant would develop cardiac failure, so she advised cardiac studies to make a definite diagnosis.

She further testified that the three heart defects which she considered, truncus, tetralogy and transposition, usually would get a child into trouble, but it might be years, depending on the individual. When she originally saw the baby she did not think it was worth doing the cardiac studies because she was not concerned about the baby.

The mother testified that during the first month of the child's life he ate well, and did not turn blue except when he cried. He slept well and reacted normally. He had no probems that required her to consult a physician, the only time being for the normal checkup after ten days,

which was a routine visit. Subsequently, the child was taken to Texas for surgery and the bills, for which claim had been made, were rejected. During the first thirty days after birth he was not on medication and was not restricted in any way; he had no problems, other than he turned a little bit blue when he cried.

A consultant cardiologist, testifying for the defendant, stated that overall mortality in complete transposition was over 90 per cent the first six months; that the most common cause seen in the first month was blueness or cyanosis; that this child's heart was markedly impaired, that he placed the child in the most restrictive classification as to capability of people with heart disease, in view of his symptoms on less than ordinary exertion for his age; that he had not read the depositions of Dr. Gluck or the attending physician; and as to whether he would have expected the child to expire in six months, he stated that the statistical chance roughly was 90 per cent within the first six months.

The partial factual chronology is that the child was born on July 5, 1965; Dr. Gluck's first contact with the baby was on July 8th; the baby was discharged from the hospital on July 10th; it was 14 days old on July 18th (the exclusionary period under the policy); it was brought back for a cardiac checkup by Dr. Gluck on August 2nd, when she changed her mind and made her first diagnosis of Taussig-Bing transposition due to a change in the baby's condition of increased blueness; cardiac studies were done August 18th, which confirmed the diagnosis of transposition but of a different type; and the first operation in Texas was done on September 1, 1965.

From the briefs of the parties it appears that from the plaintiff's point of view the question is whether the policy involved covers a child who was diagnosed and treated after reaching the age of 14 days, as having a congenital condition; or, as the defendant states it, whether or not the infant had a "sickness" which was "contracted and commenced" during the time the policy was in force as to him.

It will be recalled that the policy insured against loss resulting from "sickness" of a covered dependent, such a dependent including an unmarried child between the ages of 14 days and 23 years inclusive.

The principle applicable to this case is found in 53 ALR2d, *Insurance—Inception of Sickness* **§3, p. 689, as follows—"It is generally recognized that the provisions in a health or hospital insurance policy requiring that the illness or disease from which the assured suffers originate a specified time after the date of the policy to be within the policy coverage are strictly construed against the insurer, and the illness, disease, or disability will ordinarily be deemed to have its inception when it first becomes manifest or active or when there is a distinct symptom or reasonable accuracy diagnose the disease." See also** *Couch on Insurance 2d,* **§41:814, and Appleman 1A,** *Insurance Law and Practice* **§406.**

In Couch it is **said, "In consequence of the distinction** between 'sickness' and 'disease,' there is coverage under a **'sickness' policy of a 'sickness' which first manifests itself during the period of the policy even though it is traceable to a diseased condition which antedated the policy, absent any element of fraud or breach of warranty or condition,**

etc., which would make the policy void or voidable. That is, it is generally recognized that provisions in a health or hospital insurance policy requiring that the illness or disease from which the insured suffers originate a specified time after the date of the policy to be within the policy coverage are strictly construed against the insurer, and the illness, disease, or disability will ordinarily be deemed to have its inception when it first becomes manifest or active, or when there is a distinct symptom or condition from which one learned in medicine can with reasonable accuracy diagnose the disease."

In Continental Casualty Company v. Gold, Fla. 194 So.2d 272, upon which both parties rely, the jury, which had been presented with conflicting evidence as to when the condition causing hospitalization first became manifest, found in favor of the claimant. The Supreme Court in affirming was inclined to believe that the weight of authority supported the trial court's instruction to the jury, which was to the effect that one is regarded as sick only when his diseased condition has advanced far enough to incapacitate him. In that case the court stated at page 275—

> In 29 Am.Jur., Insurance, §1154, 301, the text reads:
>
> "The words 'sickness' and 'disease' are technically synonymous, but when given the popular meaning as required in construing a contract of insurance, 'sickness' is a condition interfering with one's usual activities, whereas disease may exist without such result; in other words, one is not ordinarily considered sick who performs his usual occupation, though some organ of the body

may be affected, but is regarded as sick when such diseased condition has advanced far enough to incapacitate him." We believe this is the general rule that governs this case; it supports the trial judge's ruling. The insurer could have protected itself in the terms of the policy in this particular had it deemed it advisable, by limiting its liability solely to a "disease" originating after a certain time stated in the policy or by stipulating that it did not cover "sickness" whose symptoms appeared prior to the effective date of the policy. This it did not do. It used the term "sickness" interchangeably with "disease" in respect to the time of its liability and, as we have seen, this word connotes incapacitation to perform one's usual occupation. See again 29 Am.Jur., Insurance, §1154, page 301, to the effect that in a situation of this kind the construction of the policy should favor the insured. The text there reads in part:

> "In determining what losses are covered by policies insuring against losses on account of disease or sickness, the general rule that ambiguous or uncertain provisions will be construed most favorably to the insured is applied. * * *"

The court believes that the facts herein come within the Gold case above.

While Dr. Gluck on July 8, 1965, found a congenital cardiac defect, it was satisfactory, and the child was discharged to its home two days later, he having mild cyanosis at the time. On July 15th, when the examining physician next saw the child after its discharge, which was within

a few days of the 14 days inclusive period under the policy, there was noted cyanosis on crying, but the rest of the examination was negative.

According to the mother, during his first month the child ate and slept well, reacted normally, was not on medication or restricted, and had no problems, other than turning a little blue when he cried.

It was well after 14 days from the child's birth that Dr. Gluck found the change in the child of considerably increased blueness on August 2nd, which led her to change her diagnosis from truncus arteriosos to transposition, to find that prognosis was poor and that it was likely that the infant would develop cardiac failure, and to suggest cardiac studies which, when she originally saw the baby, she did not think worth doing because she was not concerned about the baby. And it was the result of the cardiac studies on August 18th, confirming transposition, which induced the reference by her to the specialist in Texas. **These facts brought the matter within the Gold case and the general statements of the law as found in ALR2d and Couch above. The sickness under the policy became active and a distinct changed condition appeared from which the heart specialist could diagnose the disease; the condition had commenced and had advanced far enough to incapacitate the child.**

The court therefore finds that the child of the plaintiff was a dependent covered by the policy and that the plaintiff is entitled to be compensated for the medical expenses rendered to said child within the provisions of said policy, and it is adjudged that judgment be and the same is entered for the plaintiff, the court retaining jurisdiction to ascertain the amount of said medical expenses, plaintiff's attorneys' fees, and costs.

District Court of Appeal of Florida,
Fourth District.

No. 72-417.

SPRINGFIELD LIFE INSURANCE COMPANY, INC., Appellant,

v.

Thomas P. BOYLE, Appellee.

272 So.2d 826

Jan. 29, 1973.

Appeal from Circuit Court for Broward County; Lamar Warren, Judge.

Francis A. C. Sevier, of Stephens, Magill, Thornton & Sevier, Miami, for appellant.

Francis D. O'Connor and Harry G. Carratt, of Morgan, Carratt & O'Connor, Fort Lauderdale, for appellee.

PER CURIAM.

We have reviewed the briefs and record on appeal and heard oral argument. On the basis thereof, we are of the opinion that no reversible error has been made to clearly appear. The judgment appealed from is, therefore, affirmed.

Affirmed.

REED, C. J., and OWEN and MAGER, JJ., concur.

District Court of Appeal of Florida,
Second District.

No. 75-151.

Jack L. TURNER, Appellant,
v.

UNION FIDELITY LIFE INSURANCE COMPANY, a corporation, Appellee.

319 So.2d 588

Sept. 12, 1975.

An insured under a disability income policy excluding coverage for "heart trouble * * * contracted within 6 months of the effective date of the policy" brought an action against the insurer to recover benefits for a period of disability resulting from a second heart attack which followed a heart attack occurring within the exclusionary period. The Circuit Court, Polk County, John H. Dewell, J., entered judgment in favor of the insurer, and the insured appealed. The District Court of Appeal, Scheb., J., held that where the second heart attack was a recurrent manifestation of an underlying coronary heart disease which manifested itself within six months of issuance of the policies, coverage did not lie.

Affirmed.

Insurance — 454.2

Under disability income insurance policy which excluded coverage for "heart trouble * * * contracted within

6 months of the effective date of the policy," second heart attack, which followed first heart attack occurring within exclusionary period, was likewise excluded from coverage under policy where second heart attack was recurrent manifestation of underlying coronary heart disease which had manifested itself in first attack.

David J. Williams, Stanley, Durrance & Wines, Auburndale, for appellant.

Michael B. Colgan and Thomas R. Bayless, Holland & Knight, Lakeland, for appellee.

SCHEB, Judge.

The question presented on appeal is whether a disability income policy which excludes coverage for ". . . heart trouble . . . contracted within 6 months of the effective date of the policy" precludes the insured from recovering benefits for a period of disability resulting from a second heart attack which followed a heart attack occurring within the exclusionary period.

The appellee, Union Fidelity Life Insurance Company (insuror), issued two separate "comprehensive insurance protection" policies on May 11, 1971 and June 24, 1971, to appellant, Jack L. Turner. Each policy provided monthly indemnity benefits during periods of disability arising from sickness or accidents. Each policy stipulated:

> . . . Tuberculosis, heart trouble, hernia and diseases in organs peculiar to females shall be covered only if contracted more than six months after the effective date of the policy. (emphasis supplied)

Turner suffered a heart attack on November 9, 1971, for which he was hospitalized until December 2, 1971. This occurred within the six month exclusionary period. Turner concedes there was, therefore, no policy coverage for the disability resulting from this initial attack. Then on November 4, 1972, Turner suffered a second heart attack caused by arteriosclerosis, the underlying cause of the first attack. He contends the disability resulting from his second attack is covered under the policies.

The trial court concluded that each of Turner's periods of disability was caused by "heart trouble" contracted on November 9, 1971, within the six months exclusionary period. Judgment was entered in favor of the insuror, and Turner appeals.

The undisputed medical evidence shows that Turner's second heart attack was a recurrent manifestation of an underlying coronary heart disease (arteriosclerosis) which manifested itself within six months of issuance of the policies. An illness, disease or disability ordinarily is deemed to have been "contracted", i.e. to have its inception when it first becomes manifest or active. See 53 A.L.R.2d 686; 17 C.J.S. Contract p. 512 (1963). The trial court, therefore, correctly determined that the disability resulting from the second heart attack was a continuation of the "heart trouble" which originally was contracted during the six months exclusionary period.

Accordingly, the judgment of the trial court is affirmed.

McNULTY, C. J., and BOARDMAN, J., concur.

District Court of Appeal of Florida,
Second District.

No. 74-970.

HOME LIFE INSURANCE COMPANY,
Appellant,
v.

Agnes C. REGUEIRA, Appellee.

May 28, 1975.
Rehearing Denied June 24, 1975.

313 So.2d 438

Widow sought to recover as beneficiary of group life policy issued to her deceased husband's employer. The Circuit Court, Hillsborough County, Laurence I. Goodrich, J., entered final summary judgment in favor of widow, and insurer appealed. The District Court of Appeal, Second District, McNulty, C. J., held that insurer had not "contested" policy within two-year limitation period of incontestability clause and that such clause was not applicable to defense against claim on ground that insured was not an employee eligible for insurance under terms of policy.

Judgment reversed and cause remanded.

I. Insurance —400.1

Insurer, which rejected claim under group life policy within two years of date of issue of policy, had not contested policy within two-year limitation period of incon-

testability clause where insurer had not invoked a judicial action, either by way of claim or defense, within two years. West's F.S.A. § 627.560.

2. Insurance —400.6

Group life policy provision that "policy shall be incontestable after two years from the date of issue, except for the nonpayment of premiums." was not applicable to defense against claim on ground that insured was not an employee eligible for insurance under terms of policy. West's F.S.A. § 627.560.

3. Insurance —400.6

Incontestability clauses within insurance policies are applicable to insurer's defenses relating to validity of policy but are not applicable to defenses relating to limitation of coverage. West's F.S.A. § 627.560.

Larry E. Christensen of Gibbons, Tucker, McEwen, Smith, Cofer & Taub, Tampa, for appellant.

Richard A. Lazzara of Levine, Freedman & Hirsch, Tampa, for appellee.

McNULTY, Chief Judge.

We consider this day the question of whether an incontestability clause contained in a group life insurance policy bars the insurer from defending against a claim on the ground that the insured was not an employee eligible for insurance under the terms of the policy. It appears to be a case of first impression in Florida.

Plaintiff-appellee sued as beneficiary of a group life insurance policy issued to her deceased husband's employer by appellant Home life. The policy covered all employees of Joe Regueira, Inc. d/b/a Florida Wholesale Liquor, a business wholly owned by the decedent. The master policy contained the following provision relating to eligibility for coverage thereunder:

> "For purposes of insurance hereunder, an active full-time employee shall mean an employee of the Employer engaging in and performing the normal duties and activities of employment on a regular basis for the Employer for not less than 30 hours per week, but in no event shall these terms be deemed to include any duties or activities performed at a person's permanent or temporary residence nor while confined in a hospital or similar institution."

The policy also contained the following incontestability clause as required by § 627.0409, F.S. 1965 (now § 627.560, F.S. 1973):

> "This policy shall be incontestable after two years from the date of issue, except for the nonpayment of premiums."

Appellant sought to defend the action on the grounds that the decedent was not indeed a full-time employee within the aforequoted eligibility provisions. The trial judge, however, held that the defense was barred under the aforesaid incontestability clause, disallowed the defense and entered a final summary judgment in favor of plain-

tiff-appellee for the benefits under the policy together with attorney's fees, interest and costs. We reverse.

[1, 2] At the outset we agree with the trial judge that appellant did not properly "contest" the policy within the two-year limitation period of the incontestability clause. Plaintiff-appellee did file the claim herein within that period, and appellant had indeed rejected it within that period. But the law is clear on the point that an insurer must "contest" a policy *by the invocation of judicial action*, either by way of claim or defense, within the limits prescribed in an incontestability clause or be forever barred thereby. Couch puts it this way:[1]

> "As a general rule, a clause in an insurance policy making it incontestable after a certain period imports the invoking of judicial action to cancel the policy, or to prevent its enforcement, either by a suit to that end, or by a defense to an action on the policy; in fact, such a clause can be taken advantage of in no other method than by a judicial contest to which the insurer and the insured, or their representatives or beneficiaries, are parties.
>
> * * *
>
> "An incontestable clause included in a life policy as required by statute contemplates and intends to require the institution within the specified period of a proceeding in court to cancel the policy on account of original invalidity, or the filing within that period, in a suit brought on the policy, of an answer setting up a ground of original invalidity to defeat recovery."

[1] 18 G. Couch, Insurance § 72.98 (2d ed. 1968).

So if the defense sought to be interposed herein is one which must be raised within the two-year contestability period, such defense is barred. We are of the view, however, that it is not such a defense; and it is here that we respectfully depart from the conclusion of the trial judge.

[3] The threshold question in these cases involving applicability of an incontestability clause is whether the claim of the insurer relates to the validity of the policy or whether it relates to limitations of coverage. If it relates to the former it is barred; if to the latter it is not.

In those cases concerned with precisely the problem we are faced with here, i.e., eligibility of an employee under a group life policy, the authorities throughout the country are divided. Those cases holding that the defense of ineligibility of the employee may be barred by the incontestability clause are exemplified by the New York case of Simpson v. Phoenix Mutual Life Insurance Co.[2] It was therein held that the eligibility of a given employee is an ascertainable fact which the insurer can, by reasonable investigation, determine within the contestability period. Therefore, that court concluded, the operative fact went to the issue of *validity* rather than to the risk assumed, i.e., coverage. We cannot agree. There are too many variables inherent in this aspect of group life insurance policies to permit acceptance of *Simpson*. The case was wrongly decided and was confounded, we think, by the sounder rationale of the Illinois court in Crawford v. Equitable Life Assurance Society of the United States.[3] That court said:[4]

[2](1969), 21 N.Y.2d 262, 299 N.Y.S.2d 835, 247 N.E.2d 655.

[3](1973), 56 Ill.2d 41, 305 N.E.2d 144.

[4]*Id.* at 149-51.

"While the broad distinction drawn . . . between a policys' limits of coverage and its validity has been quite generally recognized, differences of opinion have arisen as to its application, particularly with respect to group insurance, sec. 6.5 *e. g.*, Keeton, Basic Text on Insurance, sec. 6.5 (d); Young, 'Incontestable—As to What?', 1964 U.Ill. L.F.) With individual life insurance the policy identifies a specific individual by name, and it is relatively easy to distinguish between a question of coverage (the death of the insured or his death from specific cause) and a question of validity created by antecedent misrepresentations on the part of the insured. In the case of group life insurance, however, the master policy undertakes to provide insurance for a collection of unnamed persons defined only in terms of membership in a class, such as the employees of a certain company. To ascertain whether a person is insured necessitates a determination of whether he is in fact a member of the class. To the extent that that determination is based upon information furnished by the employer or by an employee or alleged employee, the question whether coverage exists tends to become intertwined with the question whether the coverage was obtained by false representations.

* * *

"We, however, consider that *the question of eligibility is one which relates to the risk assumed and that a defense based on lack of eligibility is therefore not foreclosed by an incontestability clause.*

"It is, of course, true that eligibility may relate to circumstances existing at the inception of the contract (although it may also arise subsequently because of a change in employment status). It is also true that it may have been determined initially upon the basis of statements made by the insured or by his employer. And it may be assumed that whether a person is an employee or is a full time employee is a matter affecting the willingness of the insurer to assume the defined risk at the defined premium charge, since employment or active or full-time employment may protect the insurer against adverse selection. See Gregg, Group Life Insurance (2d ed.) 34-36.

"A challenge to eligibility does not, however, involve an attack by the insurer on the validity of the master policy. The defendant is not seeking to set aside the policy because of the misrepresentations made and the only aspect of the insurance plan which is affected is the payment sought by a single beneficiary. Moreover, even as to that beneficiary, while the defendant may have relied on his representations as well as those of the decedent, the defendant's success in this litigation does not require that the defendant establish the falsity of those representations as such . . . [It is] the fact of eligibility or ineligibility which would be decisive, not what prior representations had been made on the subject.

* * *

"A further factor which we deem significant was expressed in Rasmussen v. Equitable Life Assurance Society of the United States, 293 Mich. 482, 487, 292 N.W. 377, 380, in connection with a group policy excluding employees over a certain age: '[A] greater social good is served by enabling employed groups to obtain the most advantageous protection that their status warrants by

restricting the invitation to particular age groups. Those who deliberately misstate their age and thus tend to lower the experience record of the group should not be placed by construction within the aegis of the incontestability provision.'

"Similarly, in the present case we can envisage the possibility of an adverse effect upon other employers if, by virtue of the incontestability clause, claims must be paid out upon the death of persons not meeting the standards of eligibility contained in the policy, in that actuarial calculations upon which the premium rate had been determined could be distorted, with the consequence of increased rates being imposed as the result of experience rating. [Citations omitted.]

* * *

"A third consideration underlying the decision we reach lies in the possibility that an employee who is eligible at the time when the policy is issued might, at some point more than two years after the issuance date, cease to be a full-time employee, or, indeed, even terminate his employment. Were the incontestability clause to be applied in such a situation, there would appear to be no manner in which payment of a claim could be resisted if the employer or employer group had failed to notify the insurer of the change in the status of the employee. We think that the termination of employment is clearly a matter which the insurer may raise, as was held by the appellate court in Baker v. Prudential Insurance Company of America, 279 Ill. App. 5. On the same reasoning we believe that raising the question whether a person ever became an employee or became an employee of the type eligible for insurance is also not barred by an incontestability clause." (Emphasis ours).

We adopt this reasoning.

In view whereof, the judgment appealed from should be, and the same is hereby, reversed; and the cause is remanded for further proceedings not inconsistent herewith.

HOBSON and GRIMES, JJ., concur.

District Court of Appeal of Florida,
First District.

No. Y-28.

TIME INSURANCE COMPANY, a Wisconsin Corporation authorized to do business in the State of Florida, Appellant,

v.

Shelton ARNOLD, Appellee.

Oct. 10, 1975.

319 So.2d 638

In action for benefits under disability policy, insurer appealed from judgment of the Circuit Court for Union County, John A. H. Murphree, J., for attorney's fee and costs. The District Court of Appeal, Smith, J., held that insurer's refusal to pay was not wrongful and did not warrant assessment of attorney's fee where it was based on erroneous statement in proof of claim submitted by beneficiary indicating that illness for which claim was made first manifested itself prior to the policy period; but that assigned error as to assessment of costs was waived by failure to brief and argue it.

Affirmed in part and reversed in part.

1. Insurance —602

Statutory provision for assessment of attorney's fees for the benefit of a beneficiary who successfully obtains

a judgment on his policy is in the nature of a penalty, to discourage wrongful refusal to pay policy benefits. West's F.S.A. § 627.428.

2. **Insurance —675**

Where disability insurer's refusal to pay benefits until more than a year after action was brought on the policy and for nearly two years after beneficiary made claim was based on physician's erroneous statement in proof of claim submitted by beneficiary indicating that illness had first manifested itself prior to the policy period and where insurer propmtly paid when it learned, at taking of physician's deposition, that the illness had first manifested itself during the policy period, prior refusal

3. **Appeal and Error —1078(1)**

Though appellant assigned as error assessment of costs, it waived the point by failing to brief and argue it.

Milton H. Baxley, II, Dell, Graham, Willcox, Barber, Rappenecker, Ryals & Henderson, Gainesville, for appellant.

Wayne M. Carroll and William R. Burwell, Wershow, Burwell, Carrol & Wershow, Gainesville, for appellee.

SMITH, Judge.

Time Insurance Company appeals from a final judgment entered in favor of its insured, appellee Arnold, for to pay was not wrongful and insurer was not liable for attorney's fee in beneficiary's action on policy. West's F.S.A. §§ 627.425, 627.428.

an attorney's fee in the amount of $1,200 and costs in the amount of $47.50 in Arnold's action for benefits under a policy of disability insurance. Time paid the policy limits during litigation and urges that it is not responsible for the payment of attorneys fees under § 627.428, F.S.1973, because it did not act in bad faith or wrongfully in withholding payment for more than a year after the action was brought and for nearly two years after Arnold made claim under the policy.

Time's policy, insuring Arnold against loss by reason of disability from "sickness which first manifests itself after the policy is in force," was issued June 1, 1971. In December 1971, Arnold was stricken with a disabling illness. On January 20, 1972, on a form supplied by Time, Arnold submitted a notice of claim reciting that his sickness began on December 1 and referring Time to his physician's statement on the reverse side of the form. There Dr. Swift described his patient's illness and, in the space provided for the date on which "symptoms first appeared," he inserted the date "Jan 1971." The record does not inform us why Dr. Swift erroneously made this entry, or to what illness if any he may conceivably have been referring to, but it is agreed that the entry was erroneous and that the symptoms of Mr. Arnold's sickness were first manifested in December 1971, after the policy became effective in June.

Time rejected Arnold's claim for disability benefits by letter in April 1972, explaining that the medical information it had received indicated that the condition disabling Arnold "had its inception prior to the issuance of your policy." Arnold then consulted attorneys who protested to Time later in April that "I find no exclusion . . .

regarding pre-existing conditions" and that, in any event, Arnold's illness did not antedate the issuance of the policy, as could be verified by Dr. Barry, Arnold's family physician whose identity was shown on the original application for insurance. The lawyer's letter concluded with a declaration that he was "not interested in a barrage of letters sparring . . . on the merits of this claim," assertions that "complaint drafting is less time consuming for me than nit-picking" and that Florida law provides attorney's fees to successful plaintiffs suing on insurance policies, and a statement that "Mr. Arnold is in need of his benefits, is entitled to them, and expects to receive them."

Within a week Time replied to Arnold's attorney, forwarded an underscored photocopy of the policy provisions excluding coverage for illnesses manifested before the policy date and explained that Time had indeed consulted Dr. Barry, who had said he had not seen Arnold since July 1969, about two years before the policy date. Time's representative also pointed out that Dr. Swift had stated on the claim report form that "the Insured's condition began January, 1971," which Time stated "would pre-exist the June 1, 1971 issue date." Mr. Arnold's attorney responded as follows a week later:

> "I reply to your letter concerning Shelton Arnold. It is no surprise to me that you decline coverage in this instance. Please do not be surprised when you receive our claim in a more appropriate forum.
>
> "You deliberately overlooked the error I pointed out concerning the date assigned by Dr. F. J. Swift concerning the date of the on set of this

condition. I would send you a corrected copy, but do not feel inclined to investigate your case for you.

"Please consider this our final notice of claim in this matter."

This communication was the last between the parties until appellee Arnold's complaint was filed in November 1973. Dr. Swift's deposition was at last taken on October 30, 1974, and the doctor then verified that his entry on the notice of claim form was erroneous. Within sixty days, Time paid to Mr. Arnold the full coverage afforded by the policy.

[1, 2] In these circumstances, it was error for the trial court to enter judgment for appellee Arnold assessing attorney's fees pursuant to § 627.428, F.S.1973. The statutory provision for assessment of reasonable attorney's fees for the benefit of a beneficiary who successfully obtained a judgment on his policy is in the nature of a penalty, to discourage wrongful refusals to pay policy benefits. *Manufacturers Life Ins. Co. v. Cave*, 295 So.2d 103 (Fla.1954), *Equitable Life Assur. Soc. of U.S. v. Nichols*, 84 So.2d 500 (Fla.1956), *Bohlinger v. Higginbotham*, 70 So.2d 911 (Fla.1974). See also our decision in *Salter v. Nat'l Indem. Co.*, 160 So.2d 147 (Fla.App. 1st, 1964).

Time's refusal in this case to pay the policy benefits was not wrongful. It promptly paid when it learned, at the taking of Dr. Swift's deposition, that the illness for which claim was made first manifested itself during the policy period. Until then, it was misled by Dr. Swift's erroneous

statement in the proof of claim which was erroneously submitted by Arnold, and for which Time bore no responsibility. Sec. 627.425, F.S.1973. While Time was patient and candid in explaining its position to appellee's attorney in correspondence during the spring of 1971, counsel's response was irascible and uncommunicative. Time had no obligation under the circumstances to doubt the erroneous information contained in the notice of claim. The assessment of attorney's fee was therefore erroneous.

[3] Although Time assigned as error the assessment of costs, appellant waived the point by failing to brief and argue it. *Tri-State Enterprises, Inc. v. Berkowitz*, 182 So.2d 40 (Fla.App. 2d, 1966); *Nasrallah v. Corley*, 180 So.2d 476 (Fla.App. 3rd, 1965). In this respect the judgment will be sustained.

Affirmed in part, reversed in part.

McCORD, Acting C. J., and MILLS, J., concur.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that three (3) copies of the foregoing Supplemental Appendix to Brief in Opposition to Petition for Certiorari were served upon Burton Young and William L. Rogers of SNYDER, YOUNG, STERN, BARRETT & TANNENBAUM, P. A., 17071 West Dixie Highway, North Miami Beach, Florida 33160, Attorneys for Petitioner, Kenneth B. Forman, by mailing three (3) copies thereof to them by United States Mail, First Class postage prepaid, pursuant to Rule 33 of this Court, this 9th day of January, 1976.

L. J. CUSHMAN
Of Counsel